



RECEIVED

JUN 14 2019

DIVISION OF MEDICAID  
EXECUTIVE DIVISION

June 11, 2019

Drew Snyder  
Director  
Division of Medicaid  
500 High Street  
Suite 1000  
Jackson, MS 39201

Mr. Snyder

We are writing to inform the Division of Medicaid of the negative impact on Regional Health One of Medicaid's proposed State Plan Amendment which would lower Part A and Part B crossover claims for Medicare and Medicaid dual eligible patients. As you know, Regional One Health serves many Mississippians each year, many of whom struggle for access to care, and is a partner in ensuring all Mississippians have access to highly specialized services like trauma and burn. Regional One Health remains committed to providing needed services to Mississippians, and we appreciate the Division's on-going efforts to work with Regional One to support our efforts to provide care to these vulnerable Mississippians.

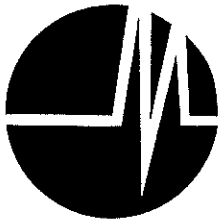
However, the proposed change -which comes on top of a proposed reduction in our supplemental payments - would cost Regional One Health an estimated \$150,000 in lost reimbursement, annually. This represents a loss of substantial revenue to an institution that already serves a disproportionate number of low-income and indigent Mississippians. We are happy to provide you with detailed data to support this estimate.

We would respectfully request that the Division reconsider its proposed State Plan Amendment, and we stand ready to work with the Mississippi Division of Medicaid to ensure and increase access to care to Mississippians.

Sincerely,

A handwritten signature in blue ink that reads 'J. Richard Wagers'.

J. Richard Wagers,  
Senior Executive Vice President/Chief Financial Officer



MISSISSIPPI HOSPITAL ASSOCIATION

May 22, 2019

Drew Snyder, Esq.  
Executive Director  
Office of the Governor, Division of Medicaid  
550 High Street, Suite 1000  
Jackson, Mississippi 39201

Re: State Plan Amendment 19-0015

Dear Mr. Snyder:

On behalf of the Mississippi Hospital Association ("MHA") and its member hospitals, please accept this letter opposing State Plan Amendment 19-0015 ("SPA 19-0015").

SPA 19-0015 purports implement the lower of logic for crossover claims which will reduce payments by over \$32 million annually. To be clear, these payments support access to hospital care for low income Medicare recipients for whom Medicaid also provides payments. Eliminating such payments jeopardizes access to care for these low income, oftentimes elderly, patients. We find it extremely disappointing that the Governor's agency would attempt the unthinkable and illegal action of reducing payments for low income Medicare recipients and thereby jeopardizing their access to care. This is even more discouraging since the Governor has recently formed a task force to address the healthcare needs of rural areas. SPA 19-015 proposes to reduce payments to rural healthcare providers. Surely, the Governor does not intend to reduce payments to rural healthcare providers who take care of low-income elderly Mississippians.

Notwithstanding the horrible optics of proposed SPA 19-0015, plain and simple, SPA 19-0015 violates state law. House Bill 71, passed during the 2009 Second Extraordinary Session of the Mississippi Legislature provides in its short title that one of the amendments to Section 43-13-117, of the Mississippi Code of 1972 is "TO PROHIBIT THE DIVISION FROM IMPLEMENTATION OF LOWER OF LOGIC REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES AND CROSSOVER CLAIMS COVERED UNDER MEDICARE PART B FOR DUALY ELIGIBLE BENEFICIARIES WITHOUT LEGISLATIVE APPROVAL." SPA 19-0015 implements the lower of logic reimbursement specifically prohibited by House Bill 71. The applicable paragraph, Mississippi Code Section 43-13-117(A)(39), has not been amended since 2009. Clearly, the legislature has not authorized the Division to implement the crossover claims logic. Such is still prohibited by the provisions of House Bill 71.

A few months after the passage of the bill, the Division submitted State Plan Amendment 2010-001 ("SPA-2010-001") to the federal Centers for Medicare and Medicaid Services. Had the Division reimbursed hospital crossover claims on January 1, 2008, in the manner provided in SPA 19-0015, then SPA 2010-001 would have been unnecessary. That House Bill 71 requires DOM to reimburse hospital crossover claims in the manner provided in SPA 2010-001 - and not SPA 2019-015 - is shown clearly in the Explanation of the Purpose of SPA 2010-001, which reads, in part, as follows:

This State Plan Amendment is being filed in order for the Division of Medicaid to comply with Miss. Code Ann. §43-13-117(39). This requires "From on and after July 1, 2009, the Division shall reimburse crossover claims for inpatient hospital services and crossover claims covered by Part B in the same manner that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method." In addition, the SPA is updated to define how the agency is reimbursing all other crossover claims.

SPA 2010-001 submitted by the Division of Medicaid to the Centers for Medicare and Medicaid Services in 2010 correctly interprets state law by paying the full amount for inpatient hospital Part A deductibles and coinsurance as well as the full amount for Part B deductibles and coinsurance. SPA 2010-001 follows the requirements of state law, the applicable provisions of which remain unchanged to this date. The Division's proposed SPA 19-0015 contradicts state law and the clear legislative purpose stated in the short title of House Bill 71 described above.

Not only did the Division file SPA 2010-001 to comply with House Bill 71, but it also has complied with House Bill 71 in other rules and policies. In Mississippi Administrative Code Title 23, Part 200, Chapter 2, Rule 2.3, C, the Division clearly states that it will reimburse the full deductible and coinsurance amount for dual eligibles. Similar requirements are found in the Medicaid Provider Billing Handbook under part 1.10 at page 2. In three distinct instances (SPA 2010-001, its Administrative Code and its Provider Billing Handbook), the Division has clearly promulgated rules and policies in compliance with the requirements of House Bill 71 regarding crossover payments for low income patients who are dually eligible for Medicare and Medicaid. Yet, despite no change in the language of House Bill 71, the Division's current Administration is proposing a State Plan Amendment that violates state law and contradicts its own Administrative Code and Provider Billing Handbook.

To reinforce the Legislature's direction to the Division regarding payments to hospitals, the Legislature provides in Mississippi Code Section 43-13-117(J) as follows:

There shall be no cuts in inpatient and outpatient hospital payments, or allowable days or volumes, as long as the hospital assessment provided in Section 43-13-145 is in effect. This subsection (J) shall not apply to decreases in payments that are a result of: reduced hospital admissions, audits or payments under

the APR-DRG or APC models, or a managed care program or similar model described in subsection (H) of this section.

The first sentence of this paragraph was enacted in House Bill 71 to make it clear that the Legislature intended to retain authority over payments to hospitals. In addition to the prohibition in Section 43-13-117(A)(39), the payment reduction contemplated in proposed SPA 19-0015 is clearly prohibited by Section 43-13-117(J) because the hospital assessment is still in effect.

In addition, the proposed SPA 19-0015 fails to comply with Mississippi Code Section 25-43-3.105 which requires the agency to prepare and file an economic impact statement and specifies the required elements of an economic impact statement. The cursory statement provided in paragraph 2 of SPA 19-0015 fails to meet the standards provided in the statute and applicable law.

Finally, MHA and counsel for MHA have submitted requests for public records to DOM in order to obtain additional documents needed to respond to SPA 2019-015. DOM has not yet produced these records. MHA therefore reserves the right to supplement this response upon receipt and review of the public records requested.

SPA 19-0015 jeopardizes access to care, clearly violates state law, contradicts the Division's own Administrative Code and Provider Billing Handbook, exceeds the Division's scope of authority and is arbitrary and capricious. We respectfully request that the Division withdraw its proposed SPA 19-0015.

Sincerely,



T. Richard Roberson  
General Counsel  
Vice President for Policy and State Advocacy

#### Attachments

cc: The Honorable Phil Bryant  
The Honorable Jim Hood  
Timothy H. Moore  
George H. Ritter, Esq.



MISSISSIPPI  
SECRETARY OF STATE

Miss. Division of Medicaid  
c/o Ginnie McCardle, Spec. Proj. Officer  
Walter Sillers Building  
550 High St.  
Suite 1000  
Jackson, MS 39201-1399  
(601) 359-6310  
<http://www.dom.state.ms.us>

NOTICE OF PROPOSED RULE ADOPTION

STATE OF MISSISSIPPI  
OFFICE OF THE GOVERNOR  
DIVISION OF MEDICAID

Specific Legal Authority authorizing the promulgation of  
Rule: Miss. Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the  
Proposed Rule : \_\_\_\_\_  
MS State Plan Attachment 4.19-B, Page 21

**Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:**

SPA2010-001 This State Plan Amendment is being filed in order for the Division of Medicaid to comply with Miss. Code Ann. §43-13-117 (39). This requires "From on and after July 1, 2009, the Division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method." In addition, the SPA is updated to define how the agency is reimbursing all other crossover claims. This filing is compliant with the filing time-line requirement in accordance to Miss Code 25.43.3113.

This rule is proposed as a ☒ Final Rule, and/or a ☒ Temporary Rule (Check one or both boxers as applicable.)

Persons may present their views on the proposed rule by addressing written comments to the agency at the above address. Persons making comments should include their name and address, as well as other contact information, and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Oral Proceeding: Check one box below:

☐ An oral proceeding is scheduled on this rule on Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Place: \_\_\_\_\_

If you wish to be heard and present evidence at the oral proceeding you must make a written request to the agency at the above address at least \_\_\_\_\_ day(s) prior to the proceeding to be placed on the agenda. The request should include your name, address, telephone number as well as other contact information; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

☒ An oral proceeding is not scheduled on this rule. Where an oral proceeding is not scheduled, an oral proceeding will be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address and telephone number of the person(s) making the request; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Economic Impact Statement: Check one box below:

- ☐ The agency has determined that an economic impact statement is not required for this rule, or  
☒ The concise summary of the economic impact statement required is attached.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Date Rule Proposed: January 26, 2010

Proposed Effective Date of Rule: July 1, 2009

  
Executive Director  
Signature and Title of Person Submitting Rule for Filing

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

State of Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- OTHER TYPES OF CARE

Item 1. Payment of Title XVIII Part A and Part B Deductible/ Coinsurance

The Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/ QMB Individual	Medicare-QMB Individual
<b>Part A Deductible</b> Inpatient Hospital	<input type="checkbox"/> limited to State Plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
<b>Part A Coinsurance</b> Inpatient Hospital	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
<b>Part A Deductible</b> Nursing Facility Hospice Home Health	<input checked="" type="checkbox"/> limited to State plan rates* <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount
<b>Part A Coinsurance</b> Nursing Facility Hospice Home Health	<input checked="" type="checkbox"/> limited to State plan rates* <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount
<b>Part B Deductible</b>	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
<b>Part B Coinsurance</b>	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount

\*The Medicaid agency will not reimburse for services that are not covered under the Medicaid State Plan.

By: Representative Dedeaux

To: Medicaid

## HOUSE BILL NO. 71

1 AN ACT RELATING TO THE ADMINISTRATION OF THE MISSISSIPPI  
2 MEDICAID LAW; TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF  
3 1972, WHICH CREATES THE DIVISION OF MEDICAID AND PRESCRIBES ITS  
4 DUTIES AND RESPONSIBILITIES, TO EXTEND THE DATE OF THE REPEALER ON  
5 THIS SECTION TO JULY 1, 2012; TO AMEND SECTION 43-13-117,  
6 MISSISSIPPI CODE OF 1972, TO CLARIFY THE LIMITATION ON INPATIENT  
7 HOSPITAL CARE REIMBURSEMENT FOR RECIPIENTS REQUIRING TRANSPLANTS;  
8 TO DELETE THE AUTHORITY FOR UNLIMITED INPATIENT HOSPITAL CARE  
9 REIMBURSEMENT FOR ELIGIBLE INFANTS IN DISPROPORTIONATE SHARE  
10 HOSPITALS; TO PROVIDE MEDICAID REIMBURSEMENT FOR OUTPATIENT  
11 SERVICES IN A CLINIC OR OTHER FACILITY THAT IS NOT LOCATED INSIDE  
12 A HOSPITAL, BUT THAT HAS BEEN DESIGNATED AS AN OUTPATIENT FACILITY  
13 BY THE HOSPITAL, AND THAT WAS IN OPERATION OR UNDER CONSTRUCTION  
14 ON JULY 1, 2009; TO PROVIDE THAT THE DIVISION OF MEDICAID, IN  
15 OBTAINING MEDICAL AND MENTAL HEALTH ASSESSMENTS FOR CHILDREN WHO  
16 ARE IN, OR AT RISK FOR BEING PUT IN, THE CUSTODY OF THE DEPARTMENT  
17 OF HUMAN SERVICES MAY ENTER A COOPERATIVE AGREEMENT WITH THE  
18 DEPARTMENT FOR THE PROVISION OF THOSE SERVICES; TO PROVIDE FOR AN  
19 INCREASE IN FEES FOR PHYSICIANS' SERVICES ON JANUARY 1, 2010; TO  
20 PROVIDE THAT THE ASSESSMENT ON HOSPITALS UNDER THE AUTHORITY OF  
21 THE MEDICARE UPPER PAYMENT LIMITS PROGRAM SHALL BE USED FOR THE  
22 SOLE PURPOSE OF FINANCING THE STATE PORTION OF THAT PROGRAM; TO  
23 PROVIDE THAT STATE-OWNED AND STATE-OPERATED FACILITIES THAT  
24 PROVIDE INPATIENT PSYCHIATRIC SERVICES TO PERSONS UNDER AGE 21 WHO  
25 ARE ELIGIBLE FOR MEDICAID REIMBURSEMENT SHALL BE REIMBURSED FOR  
26 THOSE SERVICES ON A FULL REASONABLE COST BASIS; TO PROHIBIT THE  
27 DIVISION FROM IMPLEMENTATION OF LOWER OF LOGIC REIMBURSEMENT FOR  
28 INPATIENT HOSPITAL SERVICES AND CROSSOVER CLAIMS COVERED UNDER  
29 MEDICARE PART B FOR DUALY ELIGIBLE BENEFICIARIES WITHOUT  
30 LEGISLATIVE APPROVAL; TO PROHIBIT THE DIVISION FROM CHANGING THE  
31 PAYMENT METHODOLOGY TO CERTAIN MEDICAID PROVIDERS WITHOUT  
32 LEGISLATIVE APPROVAL; TO PROVIDE THAT CUTS UNDER THE MEDICAID  
33 PROGRAM DUE TO SHORTFALLS SHALL BE VERIFIED BY THE PEER COMMITTEE  
34 AND SHALL ONLY BE EFFECTIVE ON FEBRUARY 1 IN FY2010; TO PROHIBIT  
35 THE DIVISION FROM IMPLEMENTING ANY MANAGED CARE PROGRAM BEYOND THE  
36 LEVEL, SCOPE OR LOCATION OF THE PROGRAM AS IT EXISTED ON OCTOBER  
37 1, 2008, UNTIL JANUARY 1, 2010; TO PROVIDE THAT ANY MANAGED CARE  
38 PROGRAM SHALL BE LIMITED TO A CERTAIN PERCENTAGE OF MEDICAID  
39 BENEFICIARIES; TO PROVIDE THAT ANY MEDICAID BENEFICIARY ENROLLED  
40 IN A MANAGED CARE PROGRAM SHALL HAVE AN ANNUAL WINDOW DURING WHICH  
41 THE BENEFICIARY MAY DISENROLL; TO PROVIDE THAT THE DIVISION SHALL  
42 NOT BE AUTHORIZED TO IMPLEMENT A MANAGED CARE PROGRAM IF IT DOES  
43 NOT RECEIVE FEDERAL WAIVERS NECESSARY FOR THE PROGRAM TO INCLUDE  
44 ALL OF THE REQUIREMENTS OF THIS ACT; TO PROVIDE THAT THE PEER  
45 COMMITTEE SHALL CONDUCT A COMPREHENSIVE PERFORMANCE EVALUATION OF  
46 THE MANAGED CARE PROGRAM, AND PROVIDE THE PERFORMANCE EVALUATION





TO THE LEGISLATURE NOT LATER THAN DECEMBER 15, 2011; TO AUTHORIZE THE DIVISION TO PUBLISH APR-DRG REIMBURSEMENT RATES BUT NOT IMPLEMENT THEM UNTIL AFTER JULY 1, 2010; TO PROVIDE THAT THE PEER COMMITTEE SHALL STUDY THE BENEFITS AND LIABILITIES OF USING APR-DRG REIMBURSEMENT RATES, AND REPORT ITS FINDINGS TO THE LEGISLATURE ON OR BEFORE DECEMBER 15, 2009; TO PROVIDE THAT THERE SHALL BE NO CUTS IN INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS AS LONG AS THE HOSPITAL ASSESSMENT PROVIDED IN SECTION 43-13-145, MISSISSIPPI CODE OF 1972, IS IN EFFECT; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR AN ANNUAL ASSESSMENT IMPOSED ON EACH HOSPITAL LICENSED IN THE STATE BASED UPON NON-MEDICARE HOSPITAL INPATIENT DAYS WITH CERTAIN CONDITIONS; TO PROVIDE THAT THE PRESENT PER BED ASSESSMENT LEVIED ON HOSPITALS SHALL BE DELETED UNLESS THE HOSPITAL ASSESSMENT DOES NOT TAKE EFFECT; TO CLARIFY THE ANNUAL ASSESSMENT IMPOSED ON NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED; TO PROVIDE THAT TAX LIENS FOR ASSESSMENTS SHALL BE FILED WITH THE CHANCERY CLERK; TO AMEND SECTION 43-13-407, MISSISSIPPI CODE OF 1972, TO CONFORM; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

**SECTION 1.** Section 43-13-107, Mississippi Code of 1972, is amended as follows:

43-13-107. (1) The Division of Medicaid is created in the Office of the Governor and established to administer this article and perform such other duties as are prescribed by law.

(2) (a) The Governor shall appoint a full-time executive director, with the advice and consent of the Senate, who shall be either (i) a physician with administrative experience in a medical care or health program, or (ii) a person holding a graduate degree in medical care administration, public health, hospital administration, or the equivalent, or (iii) a person holding a bachelor's degree in business administration or hospital administration, with at least ten (10) years' experience in management-level administration of Medicaid programs. The executive director shall be the official secretary and legal custodian of the records of the division; shall be the agent of the division for the purpose of receiving all service of process, summons and notices directed to the division; shall perform such other duties as the Governor may prescribe from time to time; and shall perform all other duties that are now or may be imposed upon him or her by law.





88                   (b) The executive director shall serve at the will and  
89 pleasure of the Governor.

90                   (c) The executive director shall, before entering upon  
91 the discharge of the duties of the office, take and subscribe to  
92 the oath of office prescribed by the Mississippi Constitution and  
93 shall file the same in the Office of the Secretary of State, and  
94 shall execute a bond in some surety company authorized to do  
95 business in the state in the penal sum of One Hundred Thousand  
96 Dollars (\$100,000.00), conditioned for the faithful and impartial  
97 discharge of the duties of the office. The premium on the bond  
98 shall be paid as provided by law out of funds appropriated to the  
99 Division of Medicaid for contractual services.

100                  (d) The executive director, with the approval of the  
101 Governor and subject to the rules and regulations of the State  
102 Personnel Board, shall employ such professional, administrative,  
103 stenographic, secretarial, clerical and technical assistance as  
104 may be necessary to perform the duties required in administering  
105 this article and fix the compensation for those persons, all in  
106 accordance with a state merit system meeting federal requirements.  
107 When the salary of the executive director is not set by law, that  
108 salary shall be set by the State Personnel Board. No employees of  
109 the Division of Medicaid shall be considered to be staff members  
110 of the immediate Office of the Governor; however, \* \* \* Section  
111 25-9-107(c) (xv) shall apply to the executive director and other  
112 administrative heads of the division.

113                  (3) (a) There is established a Medical Care Advisory  
114 Committee, which shall be the committee that is required by  
115 federal regulation to advise the Division of Medicaid about health  
116 and medical care services.

117                  (b) The advisory committee shall consist of not less  
118 than eleven (11) members, as follows:



(i) The Governor shall appoint five (5) members, one (1) from each congressional district and one (1) from the state at large;

(ii) The Lieutenant Governor shall appoint three (3) members, one (1) from each Supreme Court district;

(iii) The Speaker of the House of Representatives shall appoint three (3) members, one (1) from each Supreme Court district.

All members appointed under this paragraph shall either be health care providers or consumers of health care services. One (1) member appointed by each of the appointing authorities shall be a board certified physician.

(c) The respective Chairmen of the House Medicaid Committee, the House Public Health and Human Services Committee, the House Appropriations Committee, the Senate Public Health and Welfare Committee and the Senate Appropriations Committee, or their designees, two (2) members of the State Senate appointed by the Lieutenant Governor and one (1) member of the House of Representatives appointed by the Speaker of the House, shall serve as ex officio nonvoting members of the advisory committee.

(d) In addition to the committee members required by paragraph (b), the advisory committee shall consist of such other members as are necessary to meet the requirements of the federal regulation applicable to the advisory committee, who shall be appointed as provided in the federal regulation.

(e) The chairmanship of the advisory committee shall be elected by the voting members of the committee annually and shall not serve more than two (2) consecutive years as chairman.

(f) The members of the advisory committee specified in paragraph (b) shall serve for terms that are concurrent with the terms of members of the Legislature, and any member appointed under paragraph (b) may be reappointed to the advisory committee. The members of the advisory committee specified in paragraph (b)



shall serve without compensation, but shall receive reimbursement to defray actual expenses incurred in the performance of committee business as authorized by law. Legislators shall receive per diem and expenses, which may be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session.

(g) The advisory committee shall meet not less than quarterly, and advisory committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(h) The executive director shall submit to the advisory committee all amendments, modifications and changes to the state plan for the operation of the Medicaid program, for review by the advisory committee before the amendments, modifications or changes may be implemented by the division.

(i) The advisory committee, among its duties and responsibilities, shall:

(i) Advise the division with respect to amendments, modifications and changes to the state plan for the operation of the Medicaid program;

(ii) Advise the division with respect to issues concerning receipt and disbursement of funds and eligibility for Medicaid;

(iii) Advise the division with respect to determining the quantity, quality and extent of medical care provided under this article;

(iv) Communicate the views of the medical care professions to the division and communicate the views of the division to the medical care professions;

(v) Gather information on reasons that medical care providers do not participate in the Medicaid program and changes that could be made in the program to encourage more providers to participate in the Medicaid program, and advise the



division with respect to encouraging physicians and other medical care providers to participate in the Medicaid program;

(vi) Provide a written report on or before November 30 of each year to the Governor, Lieutenant Governor and Speaker of the House of Representatives.

(4) (a) There is established a Drug Use Review Board, which shall be the board that is required by federal law to:

(i) Review and initiate retrospective drug use, review including ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving Medicaid benefits or associated with specific drugs or groups of drugs.

(ii) Review and initiate ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews.

(iii) On an ongoing basis, assess data on drug use against explicit predetermined standards using the compendia and literature set forth in federal law and regulations.

(b) The board shall consist of not less than twelve (12) members appointed by the Governor, or his designee.

(c) The board shall meet at least quarterly, and board members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(d) The board meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to board members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The board meetings



shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Board meetings conducted in violation of this section shall be deemed unlawful.

(5) (a) There is established a Pharmacy and Therapeutics Committee, which shall be appointed by the Governor, or his designee.

(b) The committee shall meet at least quarterly, and committee members shall be furnished written notice of the meetings at least ten (10) days before the date of the meeting.

(c) The committee meetings shall be open to the public, members of the press, legislators and consumers. Additionally, all documents provided to committee members shall be available to members of the Legislature in the same manner, and shall be made available to others for a reasonable fee for copying. However, patient confidentiality and provider confidentiality shall be protected by blinding patient names and provider names with numerical or other anonymous identifiers. The committee meetings shall be subject to the Open Meetings Act (Sections 25-41-1 through 25-41-17). Committee meetings conducted in violation of this section shall be deemed unlawful.

(d) After a thirty-day public notice, the executive director, or his or her designee, shall present the division's recommendation regarding prior approval for a therapeutic class of drugs to the committee. However, in circumstances where the division deems it necessary for the health and safety of Medicaid beneficiaries, the division may present to the committee its recommendations regarding a particular drug without a thirty-day public notice. In making that presentation, the division shall state to the committee the circumstances that precipitate the need for the committee to review the status of a particular drug without a thirty-day public notice. The committee may determine whether or not to review the particular drug under the circumstances stated by the division without a thirty-day public



notice. If the committee determines to review the status of the particular drug, it shall make its recommendations to the division, after which the division shall file those recommendations for a thirty-day public comment under \* \* \* Section 25-43-7(1).

(e) Upon reviewing the information and recommendations, the committee shall forward a written recommendation approved by a majority of the committee to the executive director or his or her designee. The decisions of the committee regarding any limitations to be imposed on any drug or its use for a specified indication shall be based on sound clinical evidence found in labeling, drug compendia, and peer reviewed clinical literature pertaining to use of the drug in the relevant population.

(f) Upon reviewing and considering all recommendations including recommendation of the committee, comments, and data, the executive director shall make a final determination whether to require prior approval of a therapeutic class of drugs, or modify existing prior approval requirements for a therapeutic class of drugs.

(g) At least thirty (30) days before the executive director implements new or amended prior authorization decisions, written notice of the executive director's decision shall be provided to all prescribing Medicaid providers, all Medicaid enrolled pharmacies, and any other party who has requested the notification. However, notice given under Section 25-43-7(1) will substitute for and meet the requirement for notice under this subsection.

(h) Members of the committee shall dispose of matters before the committee in an unbiased and professional manner. If a matter being considered by the committee presents a real or apparent conflict of interest for any member of the committee, that member shall disclose the conflict in writing to the



committee chair and recuse himself or herself from any discussions and/or actions on the matter.

(6) This section shall stand repealed on July 1, 2012.

**SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is amended as follows:

**[The following amendments to this section shall not become effective until the hospital assessment provided for in the 2009 amendments to Section 43-13-145 becomes effective. If the hospital assessment shall not take effect and/or shall cease to be imposed, the provisions of Section 43-13-117 shall remain in effect as existed on June 30, 2009.]**

43-13-117. (A) Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of the division, with approval of the Governor, of the following types of care and services rendered to eligible applicants who have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant hospital stay count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division. \* \* \*

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat





spasticity that is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars (\$10,000.00) per year per recipient.

(2) Outpatient hospital services.

(a) Emergency services. The division shall allow six (6) medically necessary emergency room visits per beneficiary per fiscal year.

(b) Other outpatient hospital services. The division shall allow benefits for other medically necessary outpatient hospital services (such as chemotherapy, radiation, surgery and therapy), including outpatient services in a clinic or other facility that is not located inside the hospital, but that has been designated as an outpatient facility by the hospital, and that was in operation or under construction on July 1, 2009, provided that the costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report. In addition, the Medicare thirty-five-mile rule will apply to those hospital clinics not located inside the hospital that are constructed after July 1, 2009. Where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the fifty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.



349 (b) From and after July 1, 1997, the division  
350 shall implement the integrated case-mix payment and quality  
351 monitoring system, which includes the fair rental system for  
352 property costs and in which recapture of depreciation is  
353 eliminated. The division may reduce the payment for hospital  
354 leave and therapeutic home leave days to the lower of the case-mix  
355 category as computed for the resident on leave using the  
356 assessment being utilized for payment at that point in time, or a  
357 case-mix score of 1.000 for nursing facilities, and shall compute  
358 case-mix scores of residents so that only services provided at the  
359 nursing facility are considered in calculating a facility's per  
360 diem.

361 (c) From and after July 1, 1997, all state-owned  
362 nursing facilities shall be reimbursed on a full reasonable cost  
363 basis.

364 (d) When a facility of a category that does not  
365 require a certificate of need for construction and that could not  
366 be eligible for Medicaid reimbursement is constructed to nursing  
367 facility specifications for licensure and certification, and the  
368 facility is subsequently converted to a nursing facility under a  
369 certificate of need that authorizes conversion only and the  
370 applicant for the certificate of need was assessed an application  
371 review fee based on capital expenditures incurred in constructing  
372 the facility, the division shall allow reimbursement for capital  
373 expenditures necessary for construction of the facility that were  
374 incurred within the twenty-four (24) consecutive calendar months  
375 immediately preceding the date that the certificate of need  
376 authorizing the conversion was issued, to the same extent that  
377 reimbursement would be allowed for construction of a new nursing  
378 facility under a certificate of need that authorizes that  
379 construction. The reimbursement authorized in this subparagraph  
380 (d) may be made only to facilities the construction of which was  
381 completed after June 30, 1989. Before the division shall be



382 authorized to make the reimbursement authorized in this  
383 subparagraph (d), the division first must have received approval  
384 from the Centers for Medicare and Medicaid Services (CMS) of the  
385 change in the state Medicaid plan providing for the reimbursement.

386 (e) The division shall develop and implement, not  
387 later than January 1, 2001, a case-mix payment add-on determined  
388 by time studies and other valid statistical data that will  
389 reimburse a nursing facility for the additional cost of caring for  
390 a resident who has a diagnosis of Alzheimer's or other related  
391 dementia and exhibits symptoms that require special care. Any  
392 such case-mix add-on payment shall be supported by a determination  
393 of additional cost. The division shall also develop and implement  
394 as part of the fair rental reimbursement system for nursing  
395 facility beds, an Alzheimer's resident bed depreciation enhanced  
396 reimbursement system that will provide an incentive to encourage  
397 nursing facilities to convert or construct beds for residents with  
398 Alzheimer's or other related dementia.

399 (f) The division shall develop and implement an  
400 assessment process for long-term care services. The division may  
401 provide the assessment and related functions directly or through  
402 contract with the area agencies on aging.

403 The division shall apply for necessary federal waivers to  
404 assure that additional services providing alternatives to nursing  
405 facility care are made available to applicants for nursing  
406 facility care.

407 (5) Periodic screening and diagnostic services for  
408 individuals under age twenty-one (21) years as are needed to  
409 identify physical and mental defects and to provide health care  
410 treatment and other measures designed to correct or ameliorate  
411 defects and physical and mental illness and conditions discovered  
412 by the screening services, regardless of whether these services  
413 are included in the state plan. The division may include in its  
414 periodic screening and diagnostic program those discretionary



services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of those services to handicapped students by public school districts using state funds that are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and mental health assessments for children who are in, or at risk of being put in, the custody of the Mississippi Department of Human Services may enter into a cooperative agreement with the Mississippi Department of Human Services for the provision of those services using state funds that are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

(6) Physician's services. The division shall allow twelve (12) physician visits annually. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended). The division may develop and implement a different reimbursement model or schedule for physician's services provided by physicians based at an academic health care center and by physicians at rural health centers that are associated with an academic health care center. From and after January 1, 2010, all fees for physicians' services that are covered only by Medicaid shall be increased to ninety percent (90%) of the rate established on January 1, 2010, and as may be adjusted each July thereafter, under Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility



services, not to exceed twenty-five (25) visits per year. All home health visits must be precertified as required by the division.

(b) [Repealed]

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the federal Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) (a) Legend and other drugs as may be determined by the division.

The division shall establish a mandatory preferred drug list. Drugs not on the mandatory preferred drug list shall be made available by utilizing prior authorization procedures established by the division.

The division may seek to establish relationships with other states in order to lower acquisition costs of prescription drugs to include single source and innovator multiple source drugs or generic drugs. In addition, if allowed by federal law or regulation, the division may seek to establish relationships with and negotiate with other countries to facilitate the acquisition of prescription drugs to include single source and innovator multiple source drugs or generic drugs, if that will lower the acquisition costs of those prescription drugs.

The division shall allow for a combination of prescriptions for single source and innovator multiple source drugs and generic drugs to meet the needs of the beneficiaries, not to exceed five



(5) prescriptions per month for each noninstitutionalized Medicaid beneficiary, with not more than two (2) of those prescriptions being for single source or innovator multiple source drugs.

The executive director may approve specific maintenance drugs for beneficiaries with certain medical conditions, which may be prescribed and dispensed in three-month supply increments.

Drugs prescribed for a resident of a psychiatric residential treatment facility must be provided in true unit doses when available. The division may require that drugs not covered by Medicare Part D for a resident of a long-term care facility be provided in true unit doses when available. Those drugs that were originally billed to the division but are not used by a resident in any of those facilities shall be returned to the billing pharmacy for credit to the division, in accordance with the guidelines of the State Board of Pharmacy and any requirements of federal law and regulation. Drugs shall be dispensed to a recipient and only one (1) dispensing fee per month may be charged. The division shall develop a methodology for reimbursing for restocked drugs, which shall include a restock fee as determined by the division not exceeding Seven Dollars and Eighty-two Cents (\$7.82).

The voluntary preferred drug list shall be expanded to function in the interim in order to have a manageable prior authorization system, thereby minimizing disruption of service to beneficiaries.

Except for those specific maintenance drugs approved by the executive director, the division shall not reimburse for any portion of a prescription that exceeds a thirty-one-day supply of the drug based on the daily dosage.

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.



514 All claims for drugs for dually eligible Medicare/Medicaid  
515 beneficiaries that are paid for by Medicare must be submitted to  
516 Medicare for payment before they may be processed by the  
517 division's online payment system.

518 The division shall develop a pharmacy policy in which drugs  
519 in tamper-resistant packaging that are prescribed for a resident  
520 of a nursing facility but are not dispensed to the resident shall  
521 be returned to the pharmacy and not billed to Medicaid, in  
522 accordance with guidelines of the State Board of Pharmacy.

523 The division shall develop and implement a method or methods  
524 by which the division will provide on a regular basis to Medicaid  
525 providers who are authorized to prescribe drugs, information about  
526 the costs to the Medicaid program of single source drugs and  
527 innovator multiple source drugs, and information about other drugs  
528 that may be prescribed as alternatives to those single source  
529 drugs and innovator multiple source drugs and the costs to the  
530 Medicaid program of those alternative drugs.

531 Notwithstanding any law or regulation, information obtained  
532 or maintained by the division regarding the prescription drug  
533 program, including trade secrets and manufacturer or labeler  
534 pricing, is confidential and not subject to disclosure except to  
535 other state agencies.

536 (b) Payment by the division for covered  
537 multisource drugs shall be limited to the lower of the upper  
538 limits established and published by the Centers for Medicare and  
539 Medicaid Services (CMS) plus a dispensing fee, or the estimated  
540 acquisition cost (EAC) as determined by the division, plus a  
541 dispensing fee, or the providers' usual and customary charge to  
542 the general public.

543 Payment for other covered drugs, other than multisource drugs  
544 with CMS upper limits, shall not exceed the lower of the estimated  
545 acquisition cost as determined by the division, plus a dispensing





546 fee or the providers' usual and customary charge to the general  
547 public.

548 Payment for nonlegend or over-the-counter drugs covered by  
549 the division shall be reimbursed at the lower of the division's  
550 estimated shelf price or the providers' usual and customary charge  
551 to the general public.

552 The dispensing fee for each new or refill prescription,  
553 including nonlegend or over-the-counter drugs covered by the  
554 division, shall be not less than Three Dollars and Ninety-one  
555 Cents (\$3.91), as determined by the division.

556 The division shall not reimburse for single source or  
557 innovator multiple source drugs if there are equally effective  
558 generic equivalents available and if the generic equivalents are  
559 the least expensive.

560 It is the intent of the Legislature that the pharmacists  
561 providers be reimbursed for the reasonable costs of filling and  
562 dispensing prescriptions for Medicaid beneficiaries.

563 (10) (a) Dental care that is an adjunct to treatment  
564 of an acute medical or surgical condition; services of oral  
565 surgeons and dentists in connection with surgery related to the  
566 jaw or any structure contiguous to the jaw or the reduction of any  
567 fracture of the jaw or any facial bone; and emergency dental  
568 extractions and treatment related thereto. On July 1, 2007, fees  
569 for dental care and surgery under authority of this paragraph (10)  
570 shall be reimbursed as provided in subparagraph (b). It is the  
571 intent of the Legislature that this rate revision for dental  
572 services will be an incentive designed to increase the number of  
573 dentists who actively provide Medicaid services. This dental  
574 services rate revision shall be known as the "James Russell Dumas  
575 Medicaid Dental Incentive Program."

576 The division shall annually determine the effect of this  
577 incentive by evaluating the number of dentists who are Medicaid  
578 providers, the number who and the degree to which they are



579 actively billing Medicaid, the geographic trends of where dentists  
580 are offering what types of Medicaid services and other statistics  
581 pertinent to the goals of this legislative intent. This data  
582 shall be presented to the Chair of the Senate Public Health and  
583 Welfare Committee and the Chair of the House Medicaid Committee.

584 (b) The Division of Medicaid shall establish a fee  
585 schedule, to be effective from and after July 1, 2007, for dental  
586 services. The schedule shall provide for a fee for each dental  
587 service that is equal to a percentile of normal and customary  
588 private provider fees, as defined by the Ingenix Customized Fee  
589 Analyzer Report, which percentile shall be determined by the  
590 division. The schedule shall be reviewed annually by the division  
591 and dental fees shall be adjusted to reflect the percentile  
592 determined by the division.

593 (c) For fiscal year 2008, the amount of state  
594 funds appropriated for reimbursement for dental care and surgery  
595 shall be increased by ten percent (10%) of the amount of state  
596 fund expenditures for that purpose for fiscal year 2007. For each  
597 of fiscal years 2009 and 2010, the amount of state funds  
598 appropriated for reimbursement for dental care and surgery shall  
599 be increased by ten percent (10%) of the amount of state fund  
600 expenditures for that purpose for the preceding fiscal year.

601 (d) The division shall establish an annual benefit  
602 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental  
603 expenditures per Medicaid-eligible recipient; however, a recipient  
604 may exceed the annual limit on dental expenditures provided in  
605 this paragraph with prior approval of the division.

606 (e) The division shall include dental services as  
607 a necessary component of overall health services provided to  
608 children who are eligible for services.

609 (f) This paragraph (10) shall stand repealed on  
610 July 1, 2012.



611           (11) Eyeglasses for all Medicaid beneficiaries who have  
612   (a) had surgery on the eyeball or ocular muscle that results in a  
613   vision change for which eyeglasses or a change in eyeglasses is  
614   medically indicated within six (6) months of the surgery and is in  
615   accordance with policies established by the division, or (b) one  
616   (1) pair every five (5) years and in accordance with policies  
617   established by the division. In either instance, the eyeglasses  
618   must be prescribed by a physician skilled in diseases of the eye  
619   or an optometrist, whichever the beneficiary may select.

620           (12) Intermediate care facility services.

621           (a) The division shall make full payment to all  
622   intermediate care facilities for the mentally retarded for each  
623   day, not exceeding eighty-four (84) days per year, that a patient  
624   is absent from the facility on home leave. Payment may be made  
625   for the following home leave days in addition to the  
626   eighty-four-day limitation: Christmas, the day before Christmas,  
627   the day after Christmas, Thanksgiving, the day before Thanksgiving  
628   and the day after Thanksgiving.

629           (b) All state-owned intermediate care facilities  
630   for the mentally retarded shall be reimbursed on a full reasonable  
631   cost basis.

632           (13) Family planning services, including drugs,  
633   supplies and devices, when those services are under the  
634   supervision of a physician or nurse practitioner.

635           (14) Clinic services. Such diagnostic, preventive,  
636   therapeutic, rehabilitative or palliative services furnished to an  
637   outpatient by or under the supervision of a physician or dentist  
638   in a facility that is not a part of a hospital but that is  
639   organized and operated to provide medical care to outpatients.  
640   Clinic services shall include any services reimbursed as  
641   outpatient hospital services that may be rendered in such a  
642   facility, including those that become so after July 1, 1991. On  
643   July 1, 1999, all fees for physicians' services reimbursed under



644 authority of this paragraph (14) shall be reimbursed at ninety  
645 percent (90%) of the rate established on January 1, 1999, and as  
646 may be adjusted each July thereafter, under Medicare (Title XVIII  
647 of the federal Social Security Act, as amended). The division may  
648 develop and implement a different reimbursement model or schedule  
649 for physician's services provided by physicians based at an  
650 academic health care center and by physicians at rural health  
651 centers that are associated with an academic health care center.

652 (15) Home- and community-based services for the elderly  
653 and disabled, as provided under Title XIX of the federal Social  
654 Security Act, as amended, under waivers, subject to the  
655 availability of funds specifically appropriated for that purpose  
656 by the Legislature.

657 (16) Mental health services. Approved therapeutic and  
658 case management services (a) provided by an approved regional  
659 mental health/retardation center established under Sections  
660 41-19-31 through 41-19-39, or by another community mental health  
661 service provider meeting the requirements of the Department of  
662 Mental Health to be an approved mental health/retardation center  
663 if determined necessary by the Department of Mental Health, using  
664 state funds that are provided from the appropriation to the State  
665 Department of Mental Health and/or funds transferred to the  
666 department by a political subdivision or instrumentality of the  
667 state and used to match federal funds under a cooperative  
668 agreement between the division and the department, or (b) provided  
669 by a facility that is certified by the State Department of Mental  
670 Health to provide therapeutic and case management services, to be  
671 reimbursed on a fee for service basis, or (c) provided in the  
672 community by a facility or program operated by the Department of  
673 Mental Health. Any such services provided by a facility described  
674 in subparagraph (b) must have the prior approval of the division  
675 to be reimbursable under this section. After June 30, 1997,  
676 mental health services provided by regional mental



677 health/retardation centers established under Sections 41-19-31  
678 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
679 and/or their subsidiaries and divisions, or by psychiatric  
680 residential treatment facilities as defined in Section 43-11-1, or  
681 by another community mental health service provider meeting the  
682 requirements of the Department of Mental Health to be an approved  
683 mental health/retardation center if determined necessary by the  
684 Department of Mental Health, shall not be included in or provided  
685 under any capitated managed care pilot program provided for under  
686 paragraph (24) of this section.

687           (17) Durable medical equipment services and medical  
688 supplies. Precertification of durable medical equipment and  
689 medical supplies must be obtained as required by the division.  
690 The Division of Medicaid may require durable medical equipment  
691 providers to obtain a surety bond in the amount and to the  
692 specifications as established by the Balanced Budget Act of 1997.

693           (18) (a) Notwithstanding any other provision of this  
694 section to the contrary, as provided in the Medicaid state plan  
695 amendment or amendments as defined in Section 43-13-145(10), the  
696 division shall make additional reimbursement to hospitals that  
697 serve a disproportionate share of low-income patients and that  
698 meet the federal requirements for those payments as provided in  
699 Section 1923 of the federal Social Security Act and any applicable  
700 regulations. It is the intent of the Legislature that the  
701 division shall draw down all available federal funds allotted to  
702 the state for disproportionate share hospitals. However, from and  
703 after January 1, 1999, \* \* \* public hospitals participating in the  
704 Medicaid disproportionate share program may be required to  
705 participate in an intergovernmental transfer program as provided  
706 in Section 1903 of the federal Social Security Act and any  
707 applicable regulations.

708           (b) The division shall establish a Medicare Upper  
709 Payment Limits Program, as defined in Section 1902(a)(30) of the



710 federal Social Security Act and any applicable federal  
711 regulations, for hospitals, and may establish a Medicare Upper  
712 Payment Limits Program for nursing facilities. The division shall  
713 assess each hospital and, if the program is established for  
714 nursing facilities, shall assess each nursing facility, for the  
715 sole purpose of financing the state portion of the Medicare Upper  
716 Payment Limits Program. The hospital assessment shall be as  
717 provided in Section 43-13-145(4)(a) and the nursing facility  
718 assessment, if established, shall be based on Medicaid utilization  
719 or other appropriate method consistent with federal regulations.  
720 The assessment will remain in effect as long as the state  
721 participates in the Medicare Upper Payment Limits Program. As  
722 provided in the Medicaid state plan amendment or amendments as  
723 defined in Section 43-13-145(10), the division shall make  
724 additional reimbursement to hospitals and, if the program is  
725 established for nursing facilities, shall make additional  
726 reimbursement to nursing facilities, for the Medicare Upper  
727 Payment Limits, as defined in Section 1902(a)(30) of the federal  
728 Social Security Act and any applicable federal regulations.

729 (19) (a) Perinatal risk management services. The  
730 division shall promulgate regulations to be effective from and  
731 after October 1, 1988, to establish a comprehensive perinatal  
732 system for risk assessment of all pregnant and infant Medicaid  
733 recipients and for management, education and follow-up for those  
734 who are determined to be at risk. Services to be performed  
735 include case management, nutrition assessment/counseling,  
736 psychosocial assessment/counseling and health education.

737 (b) Early intervention system services. The  
738 division shall cooperate with the State Department of Health,  
739 acting as lead agency, in the development and implementation of a  
740 statewide system of delivery of early intervention services, under  
741 Part C of the Individuals with Disabilities Education Act (IDEA).  
742 The State Department of Health shall certify annually in writing



743 to the executive director of the division the dollar amount of  
744 state early intervention funds available that will be utilized as  
745 a certified match for Medicaid matching funds. Those funds then  
746 shall be used to provide expanded targeted case management  
747 services for Medicaid eligible children with special needs who are  
748 eligible for the state's early intervention system.

749 Qualifications for persons providing service coordination shall be  
750 determined by the State Department of Health and the Division of  
751 Medicaid.

752 (20) Home- and community-based services for physically  
753 disabled approved services as allowed by a waiver from the United  
754 States Department of Health and Human Services for home- and  
755 community-based services for physically disabled people using  
756 state funds that are provided from the appropriation to the State  
757 Department of Rehabilitation Services and used to match federal  
758 funds under a cooperative agreement between the division and the  
759 department, provided that funds for these services are  
760 specifically appropriated to the Department of Rehabilitation  
761 Services.

762 (21) Nurse practitioner services. Services furnished  
763 by a registered nurse who is licensed and certified by the  
764 Mississippi Board of Nursing as a nurse practitioner, including,  
765 but not limited to, nurse anesthetists, nurse midwives, family  
766 nurse practitioners, family planning nurse practitioners,  
767 pediatric nurse practitioners, obstetrics-gynecology nurse  
768 practitioners and neonatal nurse practitioners, under regulations  
769 adopted by the division. Reimbursement for those services shall  
770 not exceed ninety percent (90%) of the reimbursement rate for  
771 comparable services rendered by a physician.

772 (22) Ambulatory services delivered in federally  
773 qualified health centers, rural health centers and clinics of the  
774 local health departments of the State Department of Health for





775 individuals eligible for Medicaid under this article based on  
776 reasonable costs as determined by the division.

777           (23) Inpatient psychiatric services. Inpatient  
778 psychiatric services to be determined by the division for  
779 recipients under age twenty-one (21) that are provided under the  
780 direction of a physician in an inpatient program in a licensed  
781 acute care psychiatric facility or in a licensed psychiatric  
782 residential treatment facility, before the recipient reaches age  
783 twenty-one (21) or, if the recipient was receiving the services  
784 immediately before he or she reached age twenty-one (21), before  
785 the earlier of the date he or she no longer requires the services  
786 or the date he or she reaches age twenty-two (22), as provided by  
787 federal regulations. Precertification of inpatient days and  
788 residential treatment days must be obtained as required by the  
789 division. From and after July 1, 2009, all state-owned and  
790 state-operated facilities that provide inpatient psychiatric  
791 services to persons under age twenty-one (21) who are eligible for  
792 Medicaid reimbursement shall be reimbursed for those services on a  
793 full reasonable cost basis.

794           (24) [Deleted]

795           (25) [Deleted]

796           (26) Hospice care. As used in this paragraph, the term  
797 "hospice care" means a coordinated program of active professional  
798 medical attention within the home and outpatient and inpatient  
799 care that treats the terminally ill patient and family as a unit,  
800 employing a medically directed interdisciplinary team. The  
801 program provides relief of severe pain or other physical symptoms  
802 and supportive care to meet the special needs arising out of  
803 physical, psychological, spiritual, social and economic stresses  
804 that are experienced during the final stages of illness and during  
805 dying and bereavement and meets the Medicare requirements for  
806 participation as a hospice as provided in federal regulations.



807                   (27) Group health plan premiums and cost sharing if it  
808 is cost effective as defined by the United States Secretary of  
809 Health and Human Services.

810                   (28) Other health insurance premiums that are cost  
811 effective as defined by the United States Secretary of Health and  
812 Human Services. Medicare eligible must have Medicare Part B  
813 before other insurance premiums can be paid.

814                   (29) The Division of Medicaid may apply for a waiver  
815 from the United States Department of Health and Human Services for  
816 home- and community-based services for developmentally disabled  
817 people using state funds that are provided from the appropriation  
818 to the State Department of Mental Health and/or funds transferred  
819 to the department by a political subdivision or instrumentality of  
820 the state and used to match federal funds under a cooperative  
821 agreement between the division and the department, provided that  
822 funds for these services are specifically appropriated to the  
823 Department of Mental Health and/or transferred to the department  
824 by a political subdivision or instrumentality of the state.

825                   (30) Pediatric skilled nursing services for eligible  
826 persons under twenty-one (21) years of age.

827                   (31) Targeted case management services for children  
828 with special needs, under waivers from the United States  
829 Department of Health and Human Services, using state funds that  
830 are provided from the appropriation to the Mississippi Department  
831 of Human Services and used to match federal funds under a  
832 cooperative agreement between the division and the department.

833                   (32) Care and services provided in Christian Science  
834 Sanatoria listed and certified by the Commission for Accreditation  
835 of Christian Science Nursing Organizations/Facilities, Inc.,  
836 rendered in connection with treatment by prayer or spiritual means  
837 to the extent that those services are subject to reimbursement  
838 under Section 1903 of the federal Social Security Act.

839                   (33) Podiatrist services.



840           (34) Assisted living services as provided through home-  
841 and community-based services under Title XIX of the federal Social  
842 Security Act, as amended, subject to the availability of funds  
843 specifically appropriated for that purpose by the Legislature.

844           (35) Services and activities authorized in Sections  
845 43-27-101 and 43-27-103, using state funds that are provided from  
846 the appropriation to the Mississippi Department of Human Services  
847 and used to match federal funds under a cooperative agreement  
848 between the division and the department.

849           (36) Nonemergency transportation services for  
850 Medicaid-eligible persons, to be provided by the Division of  
851 Medicaid. The division may contract with additional entities to  
852 administer nonemergency transportation services as it deems  
853 necessary. All providers shall have a valid driver's license,  
854 vehicle inspection sticker, valid vehicle license tags and a  
855 standard liability insurance policy covering the vehicle. The  
856 division may pay providers a flat fee based on mileage tiers, or  
857 in the alternative, may reimburse on actual miles traveled. The  
858 division may apply to the Center for Medicare and Medicaid  
859 Services (CMS) for a waiver to draw federal matching funds for  
860 nonemergency transportation services as a covered service instead  
861 of an administrative cost. The PEER Committee shall conduct a  
862 performance evaluation of the nonemergency transportation program  
863 to evaluate the administration of the program and the providers of  
864 transportation services to determine the most cost-effective ways  
865 of providing nonemergency transportation services to the patients  
866 served under the program. The performance evaluation shall be  
867 completed and provided to the members of the Senate Public Health  
868 and Welfare Committee and the House Medicaid Committee not later  
869 than January 15, 2008.

870           (37) [Deleted]

871           (38) Chiropractic services. A chiropractor's manual  
872 manipulation of the spine to correct a subluxation, if x-ray



873 demonstrates that a subluxation exists and if the subluxation has  
874 resulted in a neuromusculoskeletal condition for which  
875 manipulation is appropriate treatment, and related spinal x-rays  
876 performed to document these conditions. Reimbursement for  
877 chiropractic services shall not exceed Seven Hundred Dollars  
878 (\$700.00) per year per beneficiary.

879 (39) Dually eligible Medicare/Medicaid beneficiaries.  
880 The division shall pay the Medicare deductible and coinsurance  
881 amounts for services available under Medicare, as determined by  
882 the division. From and after July 1, 2009, the division shall  
883 reimburse crossover claims for inpatient hospital services and  
884 crossover claims covered under Medicare Part B in the same manner  
885 that was in effect on January 1, 2008, unless specifically  
886 authorized by the Legislature to change this method.

887 (40) [Deleted]

888 (41) Services provided by the State Department of  
889 Rehabilitation Services for the care and rehabilitation of persons  
890 with spinal cord injuries or traumatic brain injuries, as allowed  
891 under waivers from the United States Department of Health and  
892 Human Services, using up to seventy-five percent (75%) of the  
893 funds that are appropriated to the Department of Rehabilitation  
894 Services from the Spinal Cord and Head Injury Trust Fund  
895 established under Section 37-33-261 and used to match federal  
896 funds under a cooperative agreement between the division and the  
897 department.

898 (42) Notwithstanding any other provision in this  
899 article to the contrary, the division may develop a population  
900 health management program for women and children health services  
901 through the age of one (1) year. This program is primarily for  
902 obstetrical care associated with low birth weight and preterm  
903 babies. The division may apply to the federal Centers for  
904 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
905 any other waivers that may enhance the program. In order to



effect cost savings, the division may develop a revised payment methodology that may include at-risk capitated payments, and may require member participation in accordance with the terms and conditions of an approved federal waiver.

(43) The division shall provide reimbursement, according to a payment schedule developed by the division, for smoking cessation medications for pregnant women during their pregnancy and other Medicaid-eligible women who are of child-bearing age.

(44) Nursing facility services for the severely disabled.

(a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.

(b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.

(45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

(46) The division shall make application to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waived program only if funds for



these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

(47) (a) Notwithstanding any other provision in this article to the contrary, the division may develop and implement disease management programs for individuals with high-cost chronic diseases and conditions, including the use of grants, waivers, demonstrations or other projects as necessary.

(b) Participation in any disease management program implemented under this paragraph (47) is optional with the individual. An individual must affirmatively elect to participate in the disease management program in order to participate, and may elect to discontinue participation in the program at any time.

(48) Pediatric long-term acute care hospital services.

(a) Pediatric long-term acute care hospital services means services provided to eligible persons under twenty-one (21) years of age by a freestanding Medicare-certified hospital that has an average length of inpatient stay greater than twenty-five (25) days and that is primarily engaged in providing chronic or long-term medical care to persons under twenty-one (21) years of age.

(b) The services under this paragraph (48) shall be reimbursed as a separate category of hospital services.

(49) The division shall establish copayments and/or coinsurance for all Medicaid services for which copayments and/or coinsurance are allowable under federal law or regulation, and shall set the amount of the copayment and/or coinsurance for each of those services at the maximum amount allowable under federal law or regulation.

(50) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons who are deaf and blind, as allowed under waivers from the United States Department of Health and Human Services to provide home-



and community-based services using state funds that are provided from the appropriation to the State Department of Rehabilitation Services or if funds are voluntarily provided by another agency.

(51) Upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility, beneficiaries shall be encouraged to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools. This physical examination and utilization of these disease management tools shall be consistent with current United States Preventive Services Task Force or other recognized authority recommendations.

For persons who are determined ineligible for Medicaid, the division will provide information and direction for accessing medical care and services in the area of their residence.

(52) Notwithstanding any provisions of this article, the division may pay enhanced reimbursement fees related to trauma care, as determined by the division in conjunction with the State Department of Health, using funds appropriated to the State Department of Health for trauma care and services and used to match federal funds under a cooperative agreement between the division and the State Department of Health. The division, in conjunction with the State Department of Health, may use grants, waivers, demonstrations, or other projects as necessary in the development and implementation of this reimbursement program.

(53) Targeted case management services for high-cost beneficiaries shall be developed by the division for all services under this section.

(54) Adult foster care services pilot program. Social and protective services on a pilot program basis in an approved foster care facility for vulnerable adults who would otherwise need care in a long-term care facility, to be implemented in an area of the state with the greatest need for such program, under



the Medicaid Waivers for the Elderly and Disabled program or an assisted living waiver. The division may use grants, waivers, demonstrations or other projects as necessary in the development and implementation of this adult foster care services pilot program.

(55) Therapy services. The plan of care for therapy services may be developed to cover a period of treatment for up to six (6) months, but in no event shall the plan of care exceed a six-month period of treatment. The projected period of treatment must be indicated on the initial plan of care and must be updated with each subsequent revised plan of care. Based on medical necessity, the division shall approve certification periods for less than or up to six (6) months, but in no event shall the certification period exceed the period of treatment indicated on the plan of care. The appeal process for any reduction in therapy services shall be consistent with the appeal process in federal regulations.

(B) Notwithstanding any other provision of this article to the contrary, the division shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this subsection (B) shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under subsection (A) (9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. From and after January 1, 2010, the reduction in the reimbursement rates required by this subsection (B) shall not apply to





1038 physicians' services. In addition, the reduction in the  
1039 reimbursement rates required by this subsection (B) shall not  
1040 apply to case management services and home-delivered meals  
1041 provided under the home- and community-based services program for  
1042 the elderly and disabled by a planning and development district  
1043 (PDD). Planning and development districts participating in the  
1044 home- and community-based services program for the elderly and  
1045 disabled as case management providers shall be reimbursed for case  
1046 management services at the maximum rate approved by the Centers  
1047 for Medicare and Medicaid Services (CMS).

1048 (C) The division may pay to those providers who participate  
1049 in and accept patient referrals from the division's emergency room  
1050 redirection program a percentage, as determined by the division,  
1051 of savings achieved according to the performance measures and  
1052 reduction of costs required of that program. Federally qualified  
1053 health centers may participate in the emergency room redirection  
1054 program, and the division may pay those centers a percentage of  
1055 any savings to the Medicaid program achieved by the centers'  
1056 accepting patient referrals through the program, as provided in  
1057 this subsection (C).

1058 (D) Notwithstanding any provision of this article, except as  
1059 authorized in the following subsection and in Section 43-13-139,  
1060 neither (a) the limitations on quantity or frequency of use of or  
1061 the fees or charges for any of the care or services available to  
1062 recipients under this section, nor (b) the payments, payment  
1063 methodology as provided below in this subsection (D), or rates of  
1064 reimbursement to providers rendering care or services authorized  
1065 under this section to recipients, may be increased, decreased or  
1066 otherwise changed from the levels in effect on July 1, 1999,  
1067 unless they are authorized by an amendment to this section by the  
1068 Legislature. However, the restriction in this subsection shall  
1069 not prevent the division from changing the payments, payment  
1070 methodology as provided below in this subsection (D), or rates of



reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement. The prohibition on any changes in payment methodology provided in this subsection (D) shall apply only to payment methodologies used for determining the rates of reimbursement for inpatient hospital services, outpatient hospital services and/or nursing facility services, except as required by federal law, and the federally mandated rebasing of rates as required by the Centers for Medicare and Medicaid Services (CMS) shall not be considered payment methodology for purposes of this subsection (D).

(E) Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

(F) The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary, shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs. However, the Governor shall not be authorized to discontinue or eliminate any service under



1104 this section that is mandatory under federal law, or to  
1105 discontinue or eliminate, or adjust income limits or resource  
1106 limits for, any eligibility category or group under Section  
1107 43-13-115. Applicable in fiscal year 2010 only, no expenditure  
1108 reductions or cost containments or increases in assessments  
1109 recommended by the Executive Director of the Division of Medicaid  
1110 shall be implemented before February 1, unless the division  
1111 projects a shortfall so great that the entire Health Care  
1112 Expendable Fund balance would be reduced to zero. Beginning in  
1113 fiscal year 2010 and in fiscal years thereafter, when Medicaid  
1114 expenditures are projected to exceed funds available for any  
1115 quarter in the fiscal year, the division shall submit the expected  
1116 shortfall information to the PEER Committee, which shall review  
1117 the computations of the division and report its findings to the  
1118 Legislative Budget Office within thirty (30) days of such  
1119 notification by the division, and not later than January 7 in any  
1120 year. If expenditure reductions or cost containments are  
1121 implemented, the Governor may implement a maximum amount of state  
1122 share expenditure reductions to providers, of which hospitals will  
1123 be responsible for twenty-five percent (25%) of provider  
1124 reductions as follows: in fiscal year 2010, the maximum amount  
1125 shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal  
1126 year 2011, the maximum amount shall be Thirty-two Million Dollars  
1127 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the  
1128 maximum amount shall be Forty Million Dollars (\$40,000,000.00).  
1129 However, instead of implementing cuts, the hospital share shall be  
1130 in the form of an additional assessment not to exceed Ten Million  
1131 Dollars (\$10,000,000.00) as provided in Section  
1132 43-13-145(4)(a)(ii). If Medicaid expenditures are projected to  
1133 exceed the amount of funds appropriated to the division in any  
1134 fiscal year in excess of the expenditure reductions to providers,  
1135 then funds shall be transferred by the State Fiscal Officer from  
1136 the Health Care Trust Fund into the Health Care Expendable Fund



and to the Governor's Office, Division of Medicaid, from the Health Care Expendable Fund, in the amount and at such time as requested by the Governor to reconcile the deficit. If the cost containment measures described above have been implemented and there are insufficient funds in the Health Care Trust Fund to reconcile any remaining deficit in any fiscal year, the Governor shall institute any other additional cost containment measures on any program or programs authorized under this article to the extent allowed under federal law. Hospitals shall be responsible for twenty-five percent (25%) of any additional imposed provider cuts. However, instead of implementing hospital expenditure reductions, the hospital reductions shall be in the form of an additional assessment not to exceed twenty-five percent (25%) of provider expenditure reductions as provided in Section 43-13-145(4)(a)(ii). It is the intent of the Legislature that the expenditures of the division during any fiscal year shall not exceed the amounts appropriated to the division for that fiscal year.

(G) Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

(H) (1) Notwithstanding any other provision of this article, the division shall not be authorized to implement any managed care program, coordinated care program, coordinated care organization, health maintenance organization or similar program



1170 in which services are paid for on a capitated basis, beyond the  
1171 level, scope or location of the program as it existed on October  
1172 1, 2008, until on or after January 1, 2010. Any managed care  
1173 program or coordinated care program implemented by the division  
1174 under this section shall be limited to a maximum of fifteen  
1175 percent (15%) of all Medicaid beneficiaries, and any Medicaid  
1176 beneficiary who is enrolled in the program shall have an annual  
1177 window of at least thirty (30) days in length during which the  
1178 beneficiary may disenroll from the program. In addition, any  
1179 payments made to providers by a managed care organization,  
1180 coordinated care organization, health maintenance organization or  
1181 other similar organization under a managed care program or  
1182 coordinated care program implemented by the division under this  
1183 section shall be considered to be regular Medicaid payments for  
1184 the purposes of calculating Medicare Upper Payment Limits (UPL)  
1185 payments and Disproportionate Share Hospital (DSH) payments to  
1186 hospitals. The division shall apply for any federal waiver or  
1187 waivers necessary to implement a managed care program or  
1188 coordinated care program that meets all of the requirements in  
1189 this paragraph. If the division does not receive a federal waiver  
1190 or waivers that authorizes it to implement a managed care program  
1191 or coordinated care program that meets all of the requirements in  
1192 this paragraph, then the division shall not be authorized to  
1193 implement a managed care program or coordinated care program.

1194 (2) All health maintenance organizations, coordinated  
1195 care organizations or other organizations paid for services on a  
1196 capitated basis by the division under any managed care program or  
1197 coordinated care program implemented by the division under this  
1198 section shall reimburse all providers in those organizations at  
1199 rates no lower than those provided under this section for  
1200 beneficiaries who are not participating in those programs.

1201 (3) No health maintenance organization, coordinated  
1202 care organization or other organization paid for services on a



1203 capitated basis by the division under any managed care program or  
1204 coordinated care program implemented by the division under this  
1205 section shall require its providers or beneficiaries to use any  
1206 pharmacy that ships, mails or delivers prescription drugs or  
1207 legend drugs or devices.

1208 (4) After a managed care program or coordinated care  
1209 program is implemented by the division under this section, the  
1210 PEER Committee shall conduct a comprehensive performance  
1211 evaluation of the managed care program or coordinated care  
1212 program, which shall include, but not be limited to, a  
1213 determination of any cost savings to the division, quality of care  
1214 to the beneficiaries, and access to care by the beneficiaries.  
1215 The PEER Committee shall provide regular reports on the status of  
1216 the managed care program or coordinated care program to the  
1217 members of the Senate Public Health and Welfare Committee and the  
1218 House Medicaid Committee, and shall complete the performance  
1219 evaluation and provide it to the members of those committees not  
1220 later than December 15, 2011. As a condition of participation in  
1221 a managed care program or coordinated care program implemented by  
1222 the division under this section, a provider must agree to provide  
1223 any information that the PEER Committee requests to conduct the  
1224 performance evaluation of the program, and all those providers  
1225 shall fully cooperate with the PEER Committee in any request to  
1226 provide information to the committee.

1227 (I) The division shall develop and publish reimbursement  
1228 rates for each APR-DRG proposed by the division at least equal to  
1229 the prevailing corresponding Medicare DRG rate or a closely  
1230 related Medicare DRG rate, applying to each hospital, the  
1231 applicable federal wage index being used by CMS for the hospital's  
1232 geographic location, but the division shall not implement that  
1233 rate schedule or APR-DRG methodology until after July 1, 2010.  
1234 The PEER Committee shall study the benefits and liabilities of  
1235 implementing an APR-DRG reimbursement rate schedule, and report



its findings to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee on or before December 15, 2009.

(J) There shall be no cuts in inpatient and outpatient hospital payments, or allowable days or volumes, as long as the hospital assessment provided in Section 43-13-145 is in effect.

(K) This section shall stand repealed on July 1, 2012.

**[If the hospital assessment in the 2009 amendments to Section 43-13-145 does not take effect and/or shall cease to be imposed, the provisions of Section 43-13-117 shall remain in effect as existed on June 30, 2009, and this section shall read as follows:]**

43-13-117. Medicaid as authorized by this article shall include payment of part or all of the costs, at the discretion of the division, with approval of the Governor, of the following types of care and services rendered to eligible applicants who have been determined to be eligible for that care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. Medicaid recipients requiring transplants shall not have those days included in the transplant case rate count against the thirty-day limit for inpatient hospital care. Precertification of inpatient days must be obtained as required by the division. The division may allow unlimited days in disproportionate hospitals as defined by the division for eligible infants and children under the age of six (6) years if certified as medically necessary as required by the division.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid



1269 Capital Cost Component utilized to determine total hospital costs  
1270 allocated to the Medicaid program.

1271 (c) Hospitals will receive an additional payment  
1272 for the implantable programmable baclofen drug pump used to treat  
1273 spasticity that is implanted on an inpatient basis. The payment  
1274 pursuant to written invoice will be in addition to the facility's  
1275 per diem reimbursement and will represent a reduction of costs on  
1276 the facility's annual cost report, and shall not exceed Ten  
1277 Thousand Dollars (\$10,000.00) per year per recipient.

1278 (2) Outpatient hospital services.

1279 (a) Emergency services. The division shall allow  
1280 six (6) medically necessary emergency room visits per beneficiary  
1281 per fiscal year.

1282 (b) Other outpatient hospital services. The  
1283 division shall allow benefits for other medically necessary  
1284 outpatient hospital services (such as chemotherapy, radiation,  
1285 surgery and therapy). Where the same services are reimbursed as  
1286 clinic services, the division may revise the rate or methodology  
1287 of outpatient reimbursement to maintain consistency, efficiency,  
1288 economy and quality of care.

1289 (3) Laboratory and x-ray services.

1290 (4) Nursing facility services.

1291 (a) The division shall make full payment to  
1292 nursing facilities for each day, not exceeding fifty-two (52) days  
1293 per year, that a patient is absent from the facility on home  
1294 leave. Payment may be made for the following home leave days in  
1295 addition to the fifty-two-day limitation: Christmas, the day  
1296 before Christmas, the day after Christmas, Thanksgiving, the day  
1297 before Thanksgiving and the day after Thanksgiving.

1298 (b) From and after July 1, 1997, the division  
1299 shall implement the integrated case-mix payment and quality  
1300 monitoring system, which includes the fair rental system for  
1301 property costs and in which recapture of depreciation is





1302 eliminated. The division may reduce the payment for hospital  
1303 leave and therapeutic home leave days to the lower of the case-mix  
1304 category as computed for the resident on leave using the  
1305 assessment being utilized for payment at that point in time, or a  
1306 case-mix score of 1.000 for nursing facilities, and shall compute  
1307 case-mix scores of residents so that only services provided at the  
1308 nursing facility are considered in calculating a facility's per  
1309 diem.

1310 (c) From and after July 1, 1997, all state-owned  
1311 nursing facilities shall be reimbursed on a full reasonable cost  
1312 basis.

1313 (d) When a facility of a category that does not  
1314 require a certificate of need for construction and that could not  
1315 be eligible for Medicaid reimbursement is constructed to nursing  
1316 facility specifications for licensure and certification, and the  
1317 facility is subsequently converted to a nursing facility under a  
1318 certificate of need that authorizes conversion only and the  
1319 applicant for the certificate of need was assessed an application  
1320 review fee based on capital expenditures incurred in constructing  
1321 the facility, the division shall allow reimbursement for capital  
1322 expenditures necessary for construction of the facility that were  
1323 incurred within the twenty-four (24) consecutive calendar months  
1324 immediately preceding the date that the certificate of need  
1325 authorizing the conversion was issued, to the same extent that  
1326 reimbursement would be allowed for construction of a new nursing  
1327 facility under a certificate of need that authorizes that  
1328 construction. The reimbursement authorized in this subparagraph  
1329 (d) may be made only to facilities the construction of which was  
1330 completed after June 30, 1989. Before the division shall be  
1331 authorized to make the reimbursement authorized in this  
1332 subparagraph (d), the division first must have received approval  
1333 from the Centers for Medicare and Medicaid Services (CMS) of the  
1334 change in the state Medicaid plan providing for the reimbursement.



1335                   (e) The division shall develop and implement, not  
1336 later than January 1, 2001, a case-mix payment add-on determined  
1337 by time studies and other valid statistical data that will  
1338 reimburse a nursing facility for the additional cost of caring for  
1339 a resident who has a diagnosis of Alzheimer's or other related  
1340 dementia and exhibits symptoms that require special care. Any  
1341 such case-mix add-on payment shall be supported by a determination  
1342 of additional cost. The division shall also develop and implement  
1343 as part of the fair rental reimbursement system for nursing  
1344 facility beds, an Alzheimer's resident bed depreciation enhanced  
1345 reimbursement system that will provide an incentive to encourage  
1346 nursing facilities to convert or construct beds for residents with  
1347 Alzheimer's or other related dementia.

1348                   (f) The division shall develop and implement an  
1349 assessment process for long-term care services. The division may  
1350 provide the assessment and related functions directly or through  
1351 contract with the area agencies on aging.

1352           The division shall apply for necessary federal waivers to  
1353 assure that additional services providing alternatives to nursing  
1354 facility care are made available to applicants for nursing  
1355 facility care.

1356                   (5) Periodic screening and diagnostic services for  
1357 individuals under age twenty-one (21) years as are needed to  
1358 identify physical and mental defects and to provide health care  
1359 treatment and other measures designed to correct or ameliorate  
1360 defects and physical and mental illness and conditions discovered  
1361 by the screening services, regardless of whether these services  
1362 are included in the state plan. The division may include in its  
1363 periodic screening and diagnostic program those discretionary  
1364 services authorized under the federal regulations adopted to  
1365 implement Title XIX of the federal Social Security Act, as  
1366 amended. The division, in obtaining physical therapy services,  
1367 occupational therapy services, and services for individuals with



1368 speech, hearing and language disorders, may enter into a  
1369 cooperative agreement with the State Department of Education for  
1370 the provision of those services to handicapped students by public  
1371 school districts using state funds that are provided from the  
1372 appropriation to the Department of Education to obtain federal  
1373 matching funds through the division. The division, in obtaining  
1374 medical and psychological evaluations for children in the custody  
1375 of the Mississippi Department of Human Services may enter into a  
1376 cooperative agreement with the Mississippi Department of Human  
1377 Services for the provision of those services using state funds  
1378 that are provided from the appropriation to the Department of  
1379 Human Services to obtain federal matching funds through the  
1380 division.

1381           (6) Physician's services. The division shall allow  
1382 twelve (12) physician visits annually. All fees for physicians'  
1383 services that are covered only by Medicaid shall be reimbursed at  
1384 ninety percent (90%) of the rate established on January 1, 1999,  
1385 and as may be adjusted each July thereafter, under Medicare (Title  
1386 XVIII of the federal Social Security Act, as amended). The  
1387 division may develop and implement a different reimbursement model  
1388 or schedule for physician's services provided by physicians based  
1389 at an academic health care center and by physicians at rural  
1390 health centers that are associated with an academic health care  
1391 center.

1392           (7) (a) Home health services for eligible persons, not  
1393 to exceed in cost the prevailing cost of nursing facility  
1394 services, not to exceed twenty-five (25) visits per year. All  
1395 home health visits must be precertified as required by the  
1396 division.

1397                       (b) [Repealed]

1398           (8) Emergency medical transportation services. On  
1399 January 1, 1994, emergency medical transportation services shall  
1400 be reimbursed at seventy percent (70%) of the rate established



1401 under Medicare (Title XVIII of the federal Social Security Act, as  
1402 amended). "Emergency medical transportation services" shall mean,  
1403 but shall not be limited to, the following services by a properly  
1404 permitted ambulance operated by a properly licensed provider in  
1405 accordance with the Emergency Medical Services Act of 1974  
1406 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced  
1407 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,  
1408 (vi) disposable supplies, (vii) similar services.

1409 (9) (a) Legend and other drugs as may be determined by  
1410 the division.

1411 The division shall establish a mandatory preferred drug list.  
1412 Drugs not on the mandatory preferred drug list shall be made  
1413 available by utilizing prior authorization procedures established  
1414 by the division.

1415 The division may seek to establish relationships with other  
1416 states in order to lower acquisition costs of prescription drugs  
1417 to include single source and innovator multiple source drugs or  
1418 generic drugs. In addition, if allowed by federal law or  
1419 regulation, the division may seek to establish relationships with  
1420 and negotiate with other countries to facilitate the acquisition  
1421 of prescription drugs to include single source and innovator  
1422 multiple source drugs or generic drugs, if that will lower the  
1423 acquisition costs of those prescription drugs.

1424 The division shall allow for a combination of prescriptions  
1425 for single source and innovator multiple source drugs and generic  
1426 drugs to meet the needs of the beneficiaries, not to exceed five  
1427 (5) prescriptions per month for each noninstitutionalized Medicaid  
1428 beneficiary, with not more than two (2) of those prescriptions  
1429 being for single source or innovator multiple source drugs.

1430 The executive director may approve specific maintenance drugs  
1431 for beneficiaries with certain medical conditions, which may be  
1432 prescribed and dispensed in three-month supply increments.



1433           Drugs prescribed for a resident of a psychiatric residential  
1434 treatment facility must be provided in true unit doses when  
1435 available. The division may require that drugs not covered by  
1436 Medicare Part D for a resident of a long-term care facility be  
1437 provided in true unit doses when available. Those drugs that were  
1438 originally billed to the division but are not used by a resident  
1439 in any of those facilities shall be returned to the billing  
1440 pharmacy for credit to the division, in accordance with the  
1441 guidelines of the State Board of Pharmacy and any requirements of  
1442 federal law and regulation. Drugs shall be dispensed to a  
1443 recipient and only one (1) dispensing fee per month may be  
1444 charged. The division shall develop a methodology for reimbursing  
1445 for restocked drugs, which shall include a restock fee as  
1446 determined by the division not exceeding Seven Dollars and  
1447 Eighty-two Cents (\$7.82).

1448           The voluntary preferred drug list shall be expanded to  
1449 function in the interim in order to have a manageable prior  
1450 authorization system, thereby minimizing disruption of service to  
1451 beneficiaries.

1452           Except for those specific maintenance drugs approved by the  
1453 executive director, the division shall not reimburse for any  
1454 portion of a prescription that exceeds a thirty-one-day supply of  
1455 the drug based on the daily dosage.

1456           The division shall develop and implement a program of payment  
1457 for additional pharmacist services, with payment to be based on  
1458 demonstrated savings, but in no case shall the total payment  
1459 exceed twice the amount of the dispensing fee.

1460           All claims for drugs for dually eligible Medicare/Medicaid  
1461 beneficiaries that are paid for by Medicare must be submitted to  
1462 Medicare for payment before they may be processed by the  
1463 division's online payment system.

1464           The division shall develop a pharmacy policy in which drugs  
1465 in tamper-resistant packaging that are prescribed for a resident



1466 of a nursing facility but are not dispensed to the resident shall  
1467 be returned to the pharmacy and not billed to Medicaid, in  
1468 accordance with guidelines of the State Board of Pharmacy.

1469       The division shall develop and implement a method or methods  
1470 by which the division will provide on a regular basis to Medicaid  
1471 providers who are authorized to prescribe drugs, information about  
1472 the costs to the Medicaid program of single source drugs and  
1473 innovator multiple source drugs, and information about other drugs  
1474 that may be prescribed as alternatives to those single source  
1475 drugs and innovator multiple source drugs and the costs to the  
1476 Medicaid program of those alternative drugs.

1477       Notwithstanding any law or regulation, information obtained  
1478 or maintained by the division regarding the prescription drug  
1479 program, including trade secrets and manufacturer or labeler  
1480 pricing, is confidential and not subject to disclosure except to  
1481 other state agencies.

1482               (b) Payment by the division for covered  
1483 multisource drugs shall be limited to the lower of the upper  
1484 limits established and published by the Centers for Medicare and  
1485 Medicaid Services (CMS) plus a dispensing fee, or the estimated  
1486 acquisition cost (EAC) as determined by the division, plus a  
1487 dispensing fee, or the providers' usual and customary charge to  
1488 the general public.

1489       Payment for other covered drugs, other than multisource drugs  
1490 with CMS upper limits, shall not exceed the lower of the estimated  
1491 acquisition cost as determined by the division, plus a dispensing  
1492 fee or the providers' usual and customary charge to the general  
1493 public.

1494       Payment for nonlegend or over-the-counter drugs covered by  
1495 the division shall be reimbursed at the lower of the division's  
1496 estimated shelf price or the providers' usual and customary charge  
1497 to the general public.



1498           The dispensing fee for each new or refill prescription,  
1499 including nonlegend or over-the-counter drugs covered by the  
1500 division, shall be not less than Three Dollars and Ninety-one  
1501 Cents (\$3.91), as determined by the division.

1502           The division shall not reimburse for single source or  
1503 innovator multiple source drugs if there are equally effective  
1504 generic equivalents available and if the generic equivalents are  
1505 the least expensive.

1506           It is the intent of the Legislature that the pharmacists  
1507 providers be reimbursed for the reasonable costs of filling and  
1508 dispensing prescriptions for Medicaid beneficiaries.

1509                   (10)   (a)   Dental care that is an adjunct to treatment  
1510 of an acute medical or surgical condition; services of oral  
1511 surgeons and dentists in connection with surgery related to the  
1512 jaw or any structure contiguous to the jaw or the reduction of any  
1513 fracture of the jaw or any facial bone; and emergency dental  
1514 extractions and treatment related thereto. On July 1, 2007, fees  
1515 for dental care and surgery under authority of this paragraph (10)  
1516 shall be reimbursed as provided in subparagraph (b). It is the  
1517 intent of the Legislature that this rate revision for dental  
1518 services will be an incentive designed to increase the number of  
1519 dentists who actively provide Medicaid services. This dental  
1520 services rate revision shall be known as the "James Russell Dumas  
1521 Medicaid Dental Incentive Program."

1522           The division shall annually determine the effect of this  
1523 incentive by evaluating the number of dentists who are Medicaid  
1524 providers, the number who and the degree to which they are  
1525 actively billing Medicaid, the geographic trends of where dentists  
1526 are offering what types of Medicaid services and other statistics  
1527 pertinent to the goals of this legislative intent. This data  
1528 shall be presented to the Chair of the Senate Public Health and  
1529 Welfare Committee and the Chair of the House Medicaid Committee.



1530                   (b) The Division of Medicaid shall establish a fee  
1531 schedule, to be effective from and after July 1, 2007, for dental  
1532 services. The schedule shall provide for a fee for each dental  
1533 service that is equal to a percentile of normal and customary  
1534 private provider fees, as defined by the Ingenix Customized Fee  
1535 Analyzer Report, which percentile shall be determined by the  
1536 division. The schedule shall be reviewed annually by the division  
1537 and dental fees shall be adjusted to reflect the percentile  
1538 determined by the division.

1539                   (c) For fiscal year 2008, the amount of state  
1540 funds appropriated for reimbursement for dental care and surgery  
1541 shall be increased by ten percent (10%) of the amount of state  
1542 fund expenditures for that purpose for fiscal year 2007. For each  
1543 of fiscal years 2009 and 2010, the amount of state funds  
1544 appropriated for reimbursement for dental care and surgery shall  
1545 be increased by ten percent (10%) of the amount of state fund  
1546 expenditures for that purpose for the preceding fiscal year.

1547                   (d) The division shall establish an annual benefit  
1548 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental  
1549 expenditures per Medicaid-eligible recipient; however, a recipient  
1550 may exceed the annual limit on dental expenditures provided in  
1551 this paragraph with prior approval of the division.

1552                   (e) The division shall include dental services as  
1553 a necessary component of overall health services provided to  
1554 children who are eligible for services.

1555                   (f) This paragraph (10) shall stand repealed on  
1556 July 1, 2010.

1557                   (11) Eyeglasses for all Medicaid beneficiaries who have  
1558 (a) had surgery on the eyeball or ocular muscle that results in a  
1559 vision change for which eyeglasses or a change in eyeglasses is  
1560 medically indicated within six (6) months of the surgery and is in  
1561 accordance with policies established by the division, or (b) one  
1562 (1) pair every five (5) years and in accordance with policies





1563 established by the division. In either instance, the eyeglasses  
1564 must be prescribed by a physician skilled in diseases of the eye  
1565 or an optometrist, whichever the beneficiary may select.

1566 (12) Intermediate care facility services.

1567 (a) The division shall make full payment to all  
1568 intermediate care facilities for the mentally retarded for each  
1569 day, not exceeding eighty-four (84) days per year, that a patient  
1570 is absent from the facility on home leave. Payment may be made  
1571 for the following home leave days in addition to the  
1572 eighty-four-day limitation: Christmas, the day before Christmas,  
1573 the day after Christmas, Thanksgiving, the day before Thanksgiving  
1574 and the day after Thanksgiving.

1575 (b) All state-owned intermediate care facilities  
1576 for the mentally retarded shall be reimbursed on a full reasonable  
1577 cost basis.

1578 (13) Family planning services, including drugs,  
1579 supplies and devices, when those services are under the  
1580 supervision of a physician or nurse practitioner.

1581 (14) Clinic services. Such diagnostic, preventive,  
1582 therapeutic, rehabilitative or palliative services furnished to an  
1583 outpatient by or under the supervision of a physician or dentist  
1584 in a facility that is not a part of a hospital but that is  
1585 organized and operated to provide medical care to outpatients.  
1586 Clinic services shall include any services reimbursed as  
1587 outpatient hospital services that may be rendered in such a  
1588 facility, including those that become so after July 1, 1991. On  
1589 July 1, 1999, all fees for physicians' services reimbursed under  
1590 authority of this paragraph (14) shall be reimbursed at ninety  
1591 percent (90%) of the rate established on January 1, 1999, and as  
1592 may be adjusted each July thereafter, under Medicare (Title XVIII  
1593 of the federal Social Security Act, as amended). The division may  
1594 develop and implement a different reimbursement model or schedule  
1595 for physician's services provided by physicians based at an



1596 academic health care center and by physicians at rural health  
1597 centers that are associated with an academic health care center.

1598 (15) Home- and community-based services for the elderly  
1599 and disabled, as provided under Title XIX of the federal Social  
1600 Security Act, as amended, under waivers, subject to the  
1601 availability of funds specifically appropriated for that purpose  
1602 by the Legislature.

1603 (16) Mental health services. Approved therapeutic and  
1604 case management services (a) provided by an approved regional  
1605 mental health/retardation center established under Sections  
1606 41-19-31 through 41-19-39, or by another community mental health  
1607 service provider meeting the requirements of the Department of  
1608 Mental Health to be an approved mental health/retardation center  
1609 if determined necessary by the Department of Mental Health, using  
1610 state funds that are provided from the appropriation to the State  
1611 Department of Mental Health and/or funds transferred to the  
1612 department by a political subdivision or instrumentality of the  
1613 state and used to match federal funds under a cooperative  
1614 agreement between the division and the department, or (b) provided  
1615 by a facility that is certified by the State Department of Mental  
1616 Health to provide therapeutic and case management services, to be  
1617 reimbursed on a fee for service basis, or (c) provided in the  
1618 community by a facility or program operated by the Department of  
1619 Mental Health. Any such services provided by a facility described  
1620 in subparagraph (b) must have the prior approval of the division  
1621 to be reimbursable under this section. After June 30, 1997,  
1622 mental health services provided by regional mental  
1623 health/retardation centers established under Sections 41-19-31  
1624 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)  
1625 and/or their subsidiaries and divisions, or by psychiatric  
1626 residential treatment facilities as defined in Section 43-11-1, or  
1627 by another community mental health service provider meeting the  
1628 requirements of the Department of Mental Health to be an approved



1629 mental health/retardation center if determined necessary by the  
1630 Department of Mental Health, shall not be included in or provided  
1631 under any capitated managed care pilot program provided for under  
1632 paragraph (24) of this section.

1633 (17) Durable medical equipment services and medical  
1634 supplies. Precertification of durable medical equipment and  
1635 medical supplies must be obtained as required by the division.  
1636 The Division of Medicaid may require durable medical equipment  
1637 providers to obtain a surety bond in the amount and to the  
1638 specifications as established by the Balanced Budget Act of 1997.

1639 (18) (a) Notwithstanding any other provision of this  
1640 section to the contrary, the division shall make additional  
1641 reimbursement to hospitals that serve a disproportionate share of  
1642 low-income patients and that meet the federal requirements for  
1643 those payments as provided in Section 1923 of the federal Social  
1644 Security Act and any applicable regulations. It is the intent of  
1645 the Legislature that the division shall draw down all available  
1646 federal funds allotted to the state for disproportionate share  
1647 hospitals. However, from and after January 1, 1999, no public  
1648 hospital shall participate in the Medicaid disproportionate share  
1649 program unless the public hospital participates in an  
1650 intergovernmental transfer program as provided in Section 1903 of  
1651 the federal Social Security Act and any applicable regulations.

1652 (b) The division shall establish a Medicare Upper  
1653 Payment Limits Program, as defined in Section 1902(a)(30) of the  
1654 federal Social Security Act and any applicable federal  
1655 regulations, for hospitals, and may establish a Medicare Upper  
1656 Payment Limits Program for nursing facilities. The division shall  
1657 assess each hospital and, if the program is established for  
1658 nursing facilities, shall assess each nursing facility, based on  
1659 Medicaid utilization or other appropriate method consistent with  
1660 federal regulations. The assessment will remain in effect as long  
1661 as the state participates in the Medicare Upper Payment Limits



1662 Program. The division shall make additional reimbursement to  
1663 hospitals and, if the program is established for nursing  
1664 facilities, shall make additional reimbursement to nursing  
1665 facilities, for the Medicare Upper Payment Limits, as defined in  
1666 Section 1902(a)(30) of the federal Social Security Act and any  
1667 applicable federal regulations.

1668 (19) (a) Perinatal risk management services. The  
1669 division shall promulgate regulations to be effective from and  
1670 after October 1, 1988, to establish a comprehensive perinatal  
1671 system for risk assessment of all pregnant and infant Medicaid  
1672 recipients and for management, education and follow-up for those  
1673 who are determined to be at risk. Services to be performed  
1674 include case management, nutrition assessment/counseling,  
1675 psychosocial assessment/counseling and health education.

1676 (b) Early intervention system services. The  
1677 division shall cooperate with the State Department of Health,  
1678 acting as lead agency, in the development and implementation of a  
1679 statewide system of delivery of early intervention services, under  
1680 Part C of the Individuals with Disabilities Education Act (IDEA).  
1681 The State Department of Health shall certify annually in writing  
1682 to the executive director of the division the dollar amount of  
1683 state early intervention funds available that will be utilized as  
1684 a certified match for Medicaid matching funds. Those funds then  
1685 shall be used to provide expanded targeted case management  
1686 services for Medicaid eligible children with special needs who are  
1687 eligible for the state's early intervention system.

1688 Qualifications for persons providing service coordination shall be  
1689 determined by the State Department of Health and the Division of  
1690 Medicaid.

1691 (20) Home- and community-based services for physically  
1692 disabled approved services as allowed by a waiver from the United  
1693 States Department of Health and Human Services for home- and  
1694 community-based services for physically disabled people using



1695 state funds that are provided from the appropriation to the State  
1696 Department of Rehabilitation Services and used to match federal  
1697 funds under a cooperative agreement between the division and the  
1698 department, provided that funds for these services are  
1699 specifically appropriated to the Department of Rehabilitation  
1700 Services.

1701           (21) Nurse practitioner services. Services furnished  
1702 by a registered nurse who is licensed and certified by the  
1703 Mississippi Board of Nursing as a nurse practitioner, including,  
1704 but not limited to, nurse anesthetists, nurse midwives, family  
1705 nurse practitioners, family planning nurse practitioners,  
1706 pediatric nurse practitioners, obstetrics-gynecology nurse  
1707 practitioners and neonatal nurse practitioners, under regulations  
1708 adopted by the division. Reimbursement for those services shall  
1709 not exceed ninety percent (90%) of the reimbursement rate for  
1710 comparable services rendered by a physician.

1711           (22) Ambulatory services delivered in federally  
1712 qualified health centers, rural health centers and clinics of the  
1713 local health departments of the State Department of Health for  
1714 individuals eligible for Medicaid under this article based on  
1715 reasonable costs as determined by the division.

1716           (23) Inpatient psychiatric services. Inpatient  
1717 psychiatric services to be determined by the division for  
1718 recipients under age twenty-one (21) that are provided under the  
1719 direction of a physician in an inpatient program in a licensed  
1720 acute care psychiatric facility or in a licensed psychiatric  
1721 residential treatment facility, before the recipient reaches age  
1722 twenty-one (21) or, if the recipient was receiving the services  
1723 immediately before he or she reached age twenty-one (21), before  
1724 the earlier of the date he or she no longer requires the services  
1725 or the date he or she reaches age twenty-two (22), as provided by  
1726 federal regulations. Precertification of inpatient days and



1727 residential treatment days must be obtained as required by the  
1728 division.

1729 (24) [Deleted]

1730 (25) [Deleted]

1731 (26) Hospice care. As used in this paragraph, the term  
1732 "hospice care" means a coordinated program of active professional  
1733 medical attention within the home and outpatient and inpatient  
1734 care that treats the terminally ill patient and family as a unit,  
1735 employing a medically directed interdisciplinary team. The  
1736 program provides relief of severe pain or other physical symptoms  
1737 and supportive care to meet the special needs arising out of  
1738 physical, psychological, spiritual, social and economic stresses  
1739 that are experienced during the final stages of illness and during  
1740 dying and bereavement and meets the Medicare requirements for  
1741 participation as a hospice as provided in federal regulations.

1742 (27) Group health plan premiums and cost sharing if it  
1743 is cost effective as defined by the United States Secretary of  
1744 Health and Human Services.

1745 (28) Other health insurance premiums that are cost  
1746 effective as defined by the United States Secretary of Health and  
1747 Human Services. Medicare eligible must have Medicare Part B  
1748 before other insurance premiums can be paid.

1749 (29) The Division of Medicaid may apply for a waiver  
1750 from the United States Department of Health and Human Services for  
1751 home- and community-based services for developmentally disabled  
1752 people using state funds that are provided from the appropriation  
1753 to the State Department of Mental Health and/or funds transferred  
1754 to the department by a political subdivision or instrumentality of  
1755 the state and used to match federal funds under a cooperative  
1756 agreement between the division and the department, provided that  
1757 funds for these services are specifically appropriated to the  
1758 Department of Mental Health and/or transferred to the department  
1759 by a political subdivision or instrumentality of the state.



1760                   (30) Pediatric skilled nursing services for eligible  
1761 persons under twenty-one (21) years of age.

1762                   (31) Targeted case management services for children  
1763 with special needs, under waivers from the United States  
1764 Department of Health and Human Services, using state funds that  
1765 are provided from the appropriation to the Mississippi Department  
1766 of Human Services and used to match federal funds under a  
1767 cooperative agreement between the division and the department.

1768                   (32) Care and services provided in Christian Science  
1769 Sanatoria listed and certified by the Commission for Accreditation  
1770 of Christian Science Nursing Organizations/Facilities, Inc.,  
1771 rendered in connection with treatment by prayer or spiritual means  
1772 to the extent that those services are subject to reimbursement  
1773 under Section 1903 of the federal Social Security Act.

1774                   (33) Podiatrist services.

1775                   (34) Assisted living services as provided through home-  
1776 and community-based services under Title XIX of the federal Social  
1777 Security Act, as amended, subject to the availability of funds  
1778 specifically appropriated for that purpose by the Legislature.

1779                   (35) Services and activities authorized in Sections  
1780 43-27-101 and 43-27-103, using state funds that are provided from  
1781 the appropriation to the Mississippi Department of Human Services  
1782 and used to match federal funds under a cooperative agreement  
1783 between the division and the department.

1784                   (36) Nonemergency transportation services for  
1785 Medicaid-eligible persons, to be provided by the Division of  
1786 Medicaid. The division may contract with additional entities to  
1787 administer nonemergency transportation services as it deems  
1788 necessary. All providers shall have a valid driver's license,  
1789 vehicle inspection sticker, valid vehicle license tags and a  
1790 standard liability insurance policy covering the vehicle. The  
1791 division may pay providers a flat fee based on mileage tiers, or  
1792 in the alternative, may reimburse on actual miles traveled. The



1793 division may apply to the Center for Medicare and Medicaid  
1794 Services (CMS) for a waiver to draw federal matching funds for  
1795 nonemergency transportation services as a covered service instead  
1796 of an administrative cost. The PEER Committee shall conduct a  
1797 performance evaluation of the nonemergency transportation program  
1798 to evaluate the administration of the program and the providers of  
1799 transportation services to determine the most cost-effective ways  
1800 of providing nonemergency transportation services to the patients  
1801 served under the program. The performance evaluation shall be  
1802 completed and provided to the members of the Senate Public Health  
1803 and Welfare Committee and the House Medicaid Committee not later  
1804 than January 15, 2008.

1805 (37) [Deleted]

1806 (38) Chiropractic services. A chiropractor's manual  
1807 manipulation of the spine to correct a subluxation, if x-ray  
1808 demonstrates that a subluxation exists and if the subluxation has  
1809 resulted in a neuromusculoskeletal condition for which  
1810 manipulation is appropriate treatment, and related spinal x-rays  
1811 performed to document these conditions. Reimbursement for  
1812 chiropractic services shall not exceed Seven Hundred Dollars  
1813 (\$700.00) per year per beneficiary.

1814 (39) Dually eligible Medicare/Medicaid beneficiaries.  
1815 The division shall pay the Medicare deductible and coinsurance  
1816 amounts for services available under Medicare, as determined by  
1817 the division.

1818 (40) [Deleted]

1819 (41) Services provided by the State Department of  
1820 Rehabilitation Services for the care and rehabilitation of persons  
1821 with spinal cord injuries or traumatic brain injuries, as allowed  
1822 under waivers from the United States Department of Health and  
1823 Human Services, using up to seventy-five percent (75%) of the  
1824 funds that are appropriated to the Department of Rehabilitation  
1825 Services from the Spinal Cord and Head Injury Trust Fund





1826 established under Section 37-33-261 and used to match federal  
1827 funds under a cooperative agreement between the division and the  
1828 department.

1829           (42) Notwithstanding any other provision in this  
1830 article to the contrary, the division may develop a population  
1831 health management program for women and children health services  
1832 through the age of one (1) year. This program is primarily for  
1833 obstetrical care associated with low birth weight and pre-term  
1834 babies. The division may apply to the federal Centers for  
1835 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or  
1836 any other waivers that may enhance the program. In order to  
1837 effect cost savings, the division may develop a revised payment  
1838 methodology that may include at-risk capitated payments, and may  
1839 require member participation in accordance with the terms and  
1840 conditions of an approved federal waiver.

1841           (43) The division shall provide reimbursement,  
1842 according to a payment schedule developed by the division, for  
1843 smoking cessation medications for pregnant women during their  
1844 pregnancy and other Medicaid-eligible women who are of  
1845 child-bearing age.

1846           (44) Nursing facility services for the severely  
1847 disabled.

1848                   (a) Severe disabilities include, but are not  
1849 limited to, spinal cord injuries, closed head injuries and  
1850 ventilator dependent patients.

1851                   (b) Those services must be provided in a long-term  
1852 care nursing facility dedicated to the care and treatment of  
1853 persons with severe disabilities, and shall be reimbursed as a  
1854 separate category of nursing facilities.

1855           (45) Physician assistant services. Services furnished  
1856 by a physician assistant who is licensed by the State Board of  
1857 Medical Licensure and is practicing with physician supervision  
1858 under regulations adopted by the board, under regulations adopted



1859 by the division. Reimbursement for those services shall not  
1860 exceed ninety percent (90%) of the reimbursement rate for  
1861 comparable services rendered by a physician.

1862 (46) The division shall make application to the federal  
1863 Centers for Medicare and Medicaid Services (CMS) for a waiver to  
1864 develop and provide services for children with serious emotional  
1865 disturbances as defined in Section 43-14-1(1), which may include  
1866 home- and community-based services, case management services or  
1867 managed care services through mental health providers certified by  
1868 the Department of Mental Health. The division may implement and  
1869 provide services under this waived program only if funds for  
1870 these services are specifically appropriated for this purpose by  
1871 the Legislature, or if funds are voluntarily provided by affected  
1872 agencies.

1873 (47) (a) Notwithstanding any other provision in this  
1874 article to the contrary, the division may develop and implement  
1875 disease management programs for individuals with high-cost chronic  
1876 diseases and conditions, including the use of grants, waivers,  
1877 demonstrations or other projects as necessary.

1878 (b) Participation in any disease management  
1879 program implemented under this paragraph (47) is optional with the  
1880 individual. An individual must affirmatively elect to participate  
1881 in the disease management program in order to participate, and  
1882 may elect to discontinue participation in the program at any time.

1883 (48) Pediatric long-term acute care hospital services.

1884 (a) Pediatric long-term acute care hospital  
1885 services means services provided to eligible persons under  
1886 twenty-one (21) years of age by a freestanding Medicare-certified  
1887 hospital that has an average length of inpatient stay greater than  
1888 twenty-five (25) days and that is primarily engaged in providing  
1889 chronic or long-term medical care to persons under twenty-one (21)  
1890 years of age.



1891 (b) The services under this paragraph (48) shall  
1892 be reimbursed as a separate category of hospital services.

1893 (49) The division shall establish copayments and/or  
1894 coinsurance for all Medicaid services for which copayments and/or  
1895 coinsurance are allowable under federal law or regulation, and  
1896 shall set the amount of the copayment and/or coinsurance for each  
1897 of those services at the maximum amount allowable under federal  
1898 law or regulation.

1899 (50) Services provided by the State Department of  
1900 Rehabilitation Services for the care and rehabilitation of persons  
1901 who are deaf and blind, as allowed under waivers from the United  
1902 States Department of Health and Human Services to provide home-  
1903 and community-based services using state funds that are provided  
1904 from the appropriation to the State Department of Rehabilitation  
1905 Services or if funds are voluntarily provided by another agency.

1906 (51) Upon determination of Medicaid eligibility and in  
1907 association with annual redetermination of Medicaid eligibility,  
1908 beneficiaries shall be encouraged to undertake a physical  
1909 examination that will establish a base-line level of health and  
1910 identification of a usual and customary source of care (a medical  
1911 home) to aid utilization of disease management tools. This  
1912 physical examination and utilization of these disease management  
1913 tools shall be consistent with current United States Preventive  
1914 Services Task Force or other recognized authority recommendations.

1915 For persons who are determined ineligible for Medicaid, the  
1916 division will provide information and direction for accessing  
1917 medical care and services in the area of their residence.

1918 (52) Notwithstanding any provisions of this article,  
1919 the division may pay enhanced reimbursement fees related to trauma  
1920 care, as determined by the division in conjunction with the State  
1921 Department of Health, using funds appropriated to the State  
1922 Department of Health for trauma care and services and used to  
1923 match federal funds under a cooperative agreement between the



1924 division and the State Department of Health. The division, in  
1925 conjunction with the State Department of Health, may use grants,  
1926 waivers, demonstrations, or other projects as necessary in the  
1927 development and implementation of this reimbursement program.

1928 (53) Targeted case management services for high-cost  
1929 beneficiaries shall be developed by the division for all services  
1930 under this section.

1931 (54) Adult foster care services pilot program. Social  
1932 and protective services on a pilot program basis in an approved  
1933 foster care facility for vulnerable adults who would otherwise  
1934 need care in a long-term care facility, to be implemented in an  
1935 area of the state with the greatest need for such program, under  
1936 the Medicaid Waivers for the Elderly and Disabled program or an  
1937 assisted living waiver. The division may use grants, waivers,  
1938 demonstrations or other projects as necessary in the development  
1939 and implementation of this adult foster care services pilot  
1940 program.

1941 (55) Therapy services. The plan of care for therapy  
1942 services may be developed to cover a period of treatment for up to  
1943 six (6) months, but in no event shall the plan of care exceed a  
1944 six-month period of treatment. The projected period of treatment  
1945 must be indicated on the initial plan of care and must be updated  
1946 with each subsequent revised plan of care. Based on medical  
1947 necessity, the division shall approve certification periods for  
1948 less than or up to six (6) months, but in no event shall the  
1949 certification period exceed the period of treatment indicated on  
1950 the plan of care. The appeal process for any reduction in therapy  
1951 services shall be consistent with the appeal process in federal  
1952 regulations.

1953 Notwithstanding any other provision of this article to the  
1954 contrary, the division shall reduce the rate of reimbursement to  
1955 providers for any service provided under this section by five  
1956 percent (5%) of the allowed amount for that service. However, the



reduction in the reimbursement rates required by this paragraph shall not apply to inpatient hospital services, nursing facility services, intermediate care facility services, psychiatric residential treatment facility services, pharmacy services provided under paragraph (9) of this section, or any service provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate. In addition, the reduction in the reimbursement rates required by this paragraph shall not apply to case management services and home-delivered meals provided under the home- and community-based services program for the elderly and disabled by a planning and development district (PDD). Planning and development districts participating in the home- and community-based services program for the elderly and disabled as case management providers shall be reimbursed for case management services at the maximum rate approved by the Centers for Medicare and Medicaid Services (CMS).

The division may pay to those providers who participate in and accept patient referrals from the division's emergency room redirection program a percentage, as determined by the division, of savings achieved according to the performance measures and reduction of costs required of that program. Federally qualified health centers may participate in the emergency room redirection program, and the division may pay those centers a percentage of any savings to the Medicaid program achieved by the centers' accepting patient referrals through the program, as provided in this paragraph.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to



recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority.

The executive director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. If current or projected expenditures of the division are reasonably anticipated to exceed the amount of funds appropriated to the division for any fiscal year, the Governor, after consultation with the executive director, shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, and when necessary, shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs. However, the Governor shall not be authorized to discontinue or eliminate any service under this section that is mandatory under federal law, or to



2023     discontinue or eliminate, or adjust income limits or resource  
2024     limits for, any eligibility category or group under Section  
2025     43-13-115. It is the intent of the Legislature that the  
2026     expenditures of the division during any fiscal year shall not  
2027     exceed the amounts appropriated to the division for that fiscal  
2028     year.

2029             Notwithstanding any other provision of this article, it shall  
2030     be the duty of each nursing facility, intermediate care facility  
2031     for the mentally retarded, psychiatric residential treatment  
2032     facility, and nursing facility for the severely disabled that is  
2033     participating in the Medicaid program to keep and maintain books,  
2034     documents and other records as prescribed by the Division of  
2035     Medicaid in substantiation of its cost reports for a period of  
2036     three (3) years after the date of submission to the Division of  
2037     Medicaid of an original cost report, or three (3) years after the  
2038     date of submission to the Division of Medicaid of an amended cost  
2039     report.

2040             **SECTION 3.** Section 43-13-145, Mississippi Code of 1972, is  
2041     amended as follows:

2042             **[If the hospital assessment provided in the following**  
2043     **amendment to subsection (4) of this section is approved by the**  
2044     **Centers for Medicare and Medicaid Services (CMS), this section**  
2045     **shall read as follows. If the hospital assessment provided in**  
2046     **subsection (4) of this section does not take effect or cease to be**  
2047     **imposed, the provisions of Section 43-13-145 shall remain in**  
2048     **effect as existed on June 30, 2009.]**

2049             43-13-145. (1) (a) Upon each nursing facility licensed by  
2050     the State of Mississippi, there is levied an assessment in an  
2051     amount set by the division, equal to the maximum rate allowed by  
2052     federal law or regulation, for each licensed and occupied bed of  
2053     the facility.



2054                   (b) A nursing facility is exempt from the assessment  
2055 levied under this subsection if the facility is operated under the  
2056 direction and control of:

2057                   (i) The United States Veterans Administration or  
2058 other agency or department of the United States government;

2059                   (ii) The State Veterans Affairs Board; or

2060                   (iii) The University of Mississippi Medical  
2061 Center.

2062       \* \* \*

2063           (2) (a) Upon each intermediate care facility for the  
2064 mentally retarded licensed by the State of Mississippi, there is  
2065 levied an assessment in an amount set by the division, equal to  
2066 the maximum rate allowed by federal law or regulation, for each  
2067 licensed and occupied bed of the facility.

2068                   (b) An intermediate care facility for the mentally  
2069 retarded is exempt from the assessment levied under this  
2070 subsection if the facility is operated under the direction and  
2071 control of:

2072                   (i) The United States Veterans Administration or  
2073 other agency or department of the United States government;

2074                   (ii) The State Veterans Affairs Board; or

2075                   (iii) The University of Mississippi Medical  
2076 Center.

2077           (3) (a) Upon each psychiatric residential treatment  
2078 facility licensed by the State of Mississippi, there is levied an  
2079 assessment in an amount set by the division, equal to the maximum  
2080 rate allowed by federal law or regulation, for each licensed and  
2081 occupied bed of the facility.

2082                   (b) A psychiatric residential treatment facility is  
2083 exempt from the assessment levied under this subsection if the  
2084 facility is operated under the direction and control of:

2085                   (i) The United States Veterans Administration or  
2086 other agency or department of the United States government;





2087 (ii) The University of Mississippi Medical Center;  
2088 or

2089 (iii) A state agency or a state facility that  
2090 either provides its own state match through intergovernmental  
2091 transfer or certification of funds to the division.

2092 (4) Hospital assessment.

2093 (a) (i) Subject to and upon fulfillment of the  
2094 requirements and conditions of paragraph (f) below, and  
2095 notwithstanding any other provisions of this section, effective  
2096 for state fiscal years 2010, 2011 and 2012, an annual assessment  
2097 on each hospital licensed in the state is imposed on each  
2098 non-Medicare hospital inpatient day as defined below at a rate  
2099 that is determined by dividing the sum prescribed in this  
2100 subparagraph (i), plus the nonfederal share necessary to maximize  
2101 the Disproportionate Share Hospital (DSH) and inpatient Medicare  
2102 Upper Payment Limits (UPL) payments, by the total number of  
2103 non-Medicare hospital inpatient days as defined below for all  
2104 licensed Mississippi hospitals, except as provided in paragraph  
2105 (d) below. If the state matching funds percentage for the  
2106 Mississippi Medicaid program is sixteen percent (16%) or less, the  
2107 sum used in the formula under this subparagraph (i) shall be  
2108 Seventy-four Million Dollars (\$74,000,000.00). If the state  
2109 matching funds percentage for the Mississippi Medicaid program is  
2110 twenty-four percent (24%) or higher, the sum used in the formula  
2111 under this subparagraph (i) shall be One Hundred Four Million  
2112 Dollars (\$104,000,000.00). If the state matching funds percentage  
2113 for the Mississippi Medicaid program is between sixteen percent  
2114 (16%) and twenty-four percent (24%), the sum used in the formula  
2115 under this subparagraph (i) shall be a pro rata amount determined  
2116 as follows: the current state matching funds percentage rate  
2117 minus sixteen percent (16%) divided by eight percent (8%)  
2118 multiplied by Thirty Million Dollars (\$30,000,000.00) and add that  
2119 amount to Seventy-four Million Dollars (\$74,000,000.00). However,



no assessment in a quarter under this subparagraph (i) may exceed the assessment in the previous quarter by more than Three Million Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would be Fifteen Million Dollars (\$15,000,000.00) on an annualized basis). The division shall publish the state matching funds percentage rate applicable to the Mississippi Medicaid program on the tenth day of the first month of each quarter and the assessment determined under the formula prescribed above shall be applicable in the quarter following any adjustment in that state matching funds percentage rate. The division shall notify each hospital licensed in the state as to any projected increases or decreases in the assessment determined under this subparagraph (i). However, if the Centers for Medicare and Medicaid Services (CMS) does not approve the provision in Section 43-13-117(39) requiring the division to reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B for dually eligible beneficiaries in the same manner that was in effect on January 1, 2008, the sum that otherwise would have been used in the formula under this subparagraph (i) shall be reduced by Seven Million Dollars (\$7,000,000.00).

(ii) In addition to the assessment provided under subparagraph (i), effective for state fiscal years 2010, 2011 and 2012 and thereafter, an additional annual assessment on each hospital licensed in the state is imposed on each non-Medicare hospital inpatient day as defined below at a rate that is determined by dividing twenty-five percent (25%) of any provider reductions in the Medicaid program as authorized in Section 43-13-117(F) for that fiscal year up to the following maximum amount, plus the nonfederal share necessary to maximize the Disproportionate Share Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL) payments, by the total number of non-Medicare hospital inpatient days as defined below for all licensed Mississippi hospitals: in fiscal year 2010, the maximum amount



2153 shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal  
2154 year 2011, the maximum amount shall be Thirty-two Million Dollars  
2155 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the  
2156 maximum amount shall be Forty Million Dollars (\$40,000,000.00).  
2157 Any such deficit in the Medicaid program shall be reviewed by the  
2158 PEER Committee as provided in Section 43-13-117(F).

2159 (iii) In addition to the assessments provided in  
2160 subparagraphs (i) and (ii), effective for state fiscal years 2010,  
2161 2011, 2012 and thereafter, an additional annual assessment on each  
2162 hospital licensed in the state is imposed pursuant to the  
2163 provisions of Section 43-13-117(F) if the cost containment  
2164 measures described therein have been implemented and there are  
2165 insufficient funds in the Health Care Trust Fund to reconcile any  
2166 remaining deficit in any fiscal year. If the Governor institutes  
2167 any other additional cost containment measures on any program or  
2168 programs authorized under the Medicaid program pursuant to Section  
2169 43-13-117(F), hospitals shall be responsible for twenty-five  
2170 percent (25%) of any such additional imposed provider cuts, which  
2171 shall be in the form of an additional assessment not to exceed the  
2172 twenty-five percent (25%) of provider expenditure reductions.  
2173 Such additional assessment shall be imposed on each non-Medicare  
2174 hospital inpatient day in the same manner as assessments are  
2175 imposed under subparagraphs (i) and (ii).

2176 (b) Payment and definitions.

2177 (i) Payment. Upon approval of the State Plan  
2178 Amendment for the division's DSH and inpatient UPL payment  
2179 methodology by CMS, the assessment shall be paid in three (3)  
2180 installments due no later than ten (10) days before the payment of  
2181 the DSH and UPL payments required by Section 43-13-117(18), which  
2182 shall be paid during the second, third and fourth quarters of the  
2183 state fiscal year.

2184 (ii) Definitions. For purposes of this subsection  
2185 (4):



2186                   1. "Non-Medicare hospital inpatient day"  
2187 means total hospital inpatient days including subcomponent days  
2188 less Medicare inpatient days including subcomponent days from the  
2189 hospital's Medicare cost report on file with CMS (for hospital  
2190 fiscal year 2006) as of May 31, 2008.

2191                   a. Total hospital inpatient days shall  
2192 be the sum of Worksheet S-3, Part 1, column 6 row 12, column 6 row  
2193 14.00, and column 6 row 14.01, excluding column 6 rows 3 and 4.

2194                   b. Hospital Medicare inpatient days  
2195 shall be the sum of Worksheet S-3, Part 1, column 4 row 12, column  
2196 4 row 14.00, and column 4 row 14.01, excluding column 4 rows 3 and  
2197 4.

2198                   c. Inpatient days shall not include  
2199 residential treatment or long-term care days.

2200                   2. "Subcomponent inpatient day" means the  
2201 number of days of care charged to a beneficiary for inpatient  
2202 hospital rehabilitation and psychiatric care services in units of  
2203 full days. A day begins at midnight and ends twenty-four (24)  
2204 hours later. A part of a day, including the day of admission and  
2205 day on which a patient returns from leave of absence, counts as a  
2206 full day. However, the day of discharge, death, or a day on which  
2207 a patient begins a leave of absence is not counted as a day unless  
2208 discharge or death occur on the day of admission. If admission  
2209 and discharge or death occur on the same day, the day is  
2210 considered a day of admission and counts as one (1) subcomponent  
2211 inpatient day.

2212                   (c) The assessment provided in this subsection is  
2213 intended to satisfy and not be in addition to the assessment and  
2214 intergovernmental transfers provided in Section 43-13-117(18).  
2215 Nothing in this act shall be construed to authorize any state  
2216 agency, division or department, or county, municipality or other  
2217 local governmental unit to license for revenue, levy or impose any



2218 other tax, fee or assessment upon hospitals in this state not  
2219 authorized by a specific statute.

2220 (d) Hospitals operated by the United States Department  
2221 of Veterans Affairs and state-operated facilities that provide  
2222 only inpatient and outpatient psychiatric services shall not be  
2223 subject to the hospital assessment provided in this subsection.

2224 (e) Multihospital systems, closure, merger and new  
2225 hospitals.

2226 (i) If a hospital conducts, operates or maintains  
2227 more than one (1) hospital licensed by the State Department of  
2228 Health, the provider shall pay the hospital assessment for each  
2229 hospital separately.

2230 (ii) Notwithstanding any other provision in this  
2231 section, if a hospital subject to this assessment operates or  
2232 conducts business only for a portion of a fiscal year, the  
2233 assessment for the state fiscal year shall be adjusted by  
2234 multiplying the assessment by a fraction, the numerator of which  
2235 is the number of days in the year during which the hospital  
2236 operates, and the denominator of which is three hundred sixty-five  
2237 (365). Immediately upon ceasing to operate, the hospital shall  
2238 pay the assessment for the year as so adjusted (to the extent not  
2239 previously paid).

2240 (f) Applicability.

2241 The hospital assessment imposed by this subsection shall not  
2242 take effect and/or shall cease to be imposed if:

2243 (i) The assessment is determined to be an  
2244 impermissible tax under Title XIX of the Social Security Act; or,

2245 (ii) CMS does not approve the division's 2009  
2246 Medicaid State Plan Amendment for its methodology for DSH and  
2247 inpatient UPL payments to hospitals under Section 43-13-117(18).

2248 This subsection (4) is repealed on July 1, 2012.

2249 (5) Each health care facility that is subject to the  
2250 provisions of this section shall keep and preserve such suitable



books and records as may be necessary to determine the amount of assessment for which it is liable under this section. The books and records shall be kept and preserved for a period of not less than five (5) years, during which time those books and records shall be open for examination during business hours by the division, the State Tax Commission, the Office of the Attorney General and the State Department of Health.

(6) Except as provided in subsection (4) of this section, the assessment levied under this section shall be collected by the division each month beginning on March 31, 2005.

(7) All assessments collected under this section shall be deposited in the Medical Care Fund created by Section 43-13-143.

(8) The assessment levied under this section shall be in addition to any other assessments, taxes or fees levied by law, and the assessment shall constitute a debt due the State of Mississippi from the time the assessment is due until it is paid.

(9) (a) If a health care facility that is liable for payment of an assessment levied by the division does not pay the assessment when it is due, the division shall give written notice to the health care facility by certified or registered mail demanding payment of the assessment within ten (10) days from the date of delivery of the notice. If the health care facility fails or refuses to pay the assessment after receiving the notice and demand from the division, the division shall withhold from any Medicaid reimbursement payments that are due to the health care facility the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. If the health care facility does not participate in the Medicaid program, the division shall turn over to the Office of the Attorney General the collection of the unpaid assessment by civil action. In any such civil action, the Office of the Attorney General shall collect the amount of the unpaid assessment and a penalty of ten percent (10%)



of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full.

(b) As an additional or alternative method for collecting unpaid assessments levied by the division, if a health care facility fails or refuses to pay the assessment after receiving notice and demand from the division, the division may file a notice of a tax lien with the chancery clerk of the county in which the health care facility is located, for the amount of the unpaid assessment and a penalty of ten percent (10%) of the amount of the assessment, plus the legal rate of interest until the assessment is paid in full. Immediately upon receipt of notice of the tax lien for the assessment, the chancery clerk shall forward the notice to the circuit clerk who shall enter the notice of the tax lien as a judgment upon the judgment roll and show in the appropriate columns the name of the health care facility as judgment debtor, the name of the division as judgment creditor, the amount of the unpaid assessment, and the date and time of enrollment. The judgment shall be valid as against mortgagees, pledgees, entrusters, purchasers, judgment creditors and other persons from the time of filing with the clerk. The amount of the judgment shall be a debt due the State of Mississippi and remain a lien upon the tangible property of the health care facility until the judgment is satisfied. The judgment shall be the equivalent of any enrolled judgment of a court of record and shall serve as authority for the issuance of writs of execution, writs of attachment or other remedial writs.

(10) As soon as possible after the effective date of this act, the Division of Medicaid shall submit to the Centers for Medicare and Medicaid Services (CMS) a state plan amendment or amendments (SPA) regarding the hospital assessment established under subsection (4) of this section. Before submission to CMS, the division shall transmit the SPA to the Medicaid Hospital Advisory Board created by Executive Order of the Governor, which



shall review and make comment on the state plan amendment or amendments submitted to CMS, and if any of the amendments are rejected, the Medicaid Hospital Advisory Board shall recommend necessary revisions to secure approval, provided that the plan is substantially intact. In addition to defining the assessment established in subsection (4) of this section, the state plan amendment or amendments shall include any amendments necessitated by House Bill No. 71, 2009 Second Extraordinary Session, and shall further provide for the following additional annual Medicare Upper Payment Limits (UPL) and Disproportionate Share Hospital (DSH) payments to hospitals located in Mississippi that participate in the Medicaid program:

(a) Privately operated and nonstate government operated general acute care hospitals, within the meaning of 42 CFR Section 447.272, that have fifty (50) or fewer licensed beds as of January 1, 2009, shall receive an additional inpatient UPL payment equal to sixty-five percent (65%) of their fiscal year 2010 hospital specific inpatient UPL gap, before any payments under this subsection.

(b) General acute care hospitals licensed within the class of state hospitals shall receive an additional inpatient UPL payment equal to twenty-eight percent (28%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments.

(c) General acute care hospitals licensed within the class of nonstate government hospitals shall receive:

(i) For fiscal year 2010, an additional inpatient UPL payment equal to fifty-six percent (56%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments, and

(ii) For state fiscal year 2011 and after, an additional inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations. (For state





2350 fiscal year 2011, the state shall use 2008 inpatient payment data.  
2351 For state fiscal year 2012, the state shall use 2009 inpatient  
2352 payment data.)

2353 (d) Free-standing psychiatric hospitals shall receive  
2354 an additional inpatient UPL payment equal to Seven Hundred Sixty  
2355 Dollars (\$760.00) for fiscal years 2010 and 2011, and Seven  
2356 Hundred Eighty Dollars (\$780.00), for fiscal year 2012 and  
2357 thereafter, less the hospital's fiscal year 2007 average Medicaid  
2358 inpatient per diem rate, multiplied by the hospital's fiscal year  
2359 2007 Medicaid inpatient days. Residential treatment days and  
2360 payments shall be excluded from this calculation. The base rate  
2361 for private free-standing psychiatric hospitals shall be that in  
2362 use January 1, 2009, which shall not be revised or recalculated so  
2363 long as the hospital assessment is in effect.

2364 (e) If for any reason the 2009 Medicaid state plan  
2365 amendment or amendments are not approved by CMS, not implemented,  
2366 discontinued, or otherwise not in effect, the following  
2367 reimbursement methodology for inpatient psychiatric services shall  
2368 immediately become effective:

2369 (i) If the services are provided by a nonpublic  
2370 licensed acute care psychiatric facility, the services shall be  
2371 reimbursed by the division using the prospective payment system  
2372 used by CMS to reimburse inpatient psychiatric services, as set  
2373 forth in Part 412, Subpart N of Title 42 of the Code of Federal  
2374 Regulations.

2375 (ii) If the services are provided by a nonpublic  
2376 hospital (as defined in Section 41-9-3(a)) that has fifty (50) or  
2377 more licensed psychiatric beds, the division shall allow the  
2378 hospital to elect whether to be reimbursed for these services  
2379 using the prospective payment system used by CMS to reimburse  
2380 psychiatric services, as set forth in Part 412, Subpart N of Title  
2381 42 of the Code of Federal Regulations. If a hospital included in  
2382 this subparagraph (ii) does not provide an affirmative election to



2383 the division, the division shall continue to reimburse the  
2384 hospital under the principles outlined in Section 43-13-117.

2385 (iii) If the services are provided by a provider  
2386 other than those specified in subparagraphs (i) and (ii) of this  
2387 paragraph, the division shall continue to reimburse the provider  
2388 under the principles outlined in Section 43-13-117.

2389 (f) In addition to other payments provided above, all  
2390 hospitals licensed within the class of private hospitals, other  
2391 than free-standing psychiatric hospitals, shall receive:

2392 (i) For fiscal year 2010, an additional inpatient  
2393 UPL payment equal to forty-nine and forty-five one-hundredths  
2394 percent (49.45%) of their fiscal year 2007 inpatient payments,  
2395 excluding DSH and UPL payments, and

2396 (ii) For state fiscal year 2011 and after, an  
2397 additional inpatient UPL payment determined by multiplying  
2398 inpatient payments, excluding DSH and UPL, by the uniform  
2399 percentage necessary to exhaust the maximum amount of UPL  
2400 inpatient payments permissible under federal regulations. (For  
2401 state fiscal year 2011, the state shall use 2008 inpatient payment  
2402 data. For state fiscal year 2012, the state shall use 2009  
2403 inpatient payment data.)

2404 (g) All hospitals satisfying the minimum federal DSH  
2405 eligibility requirements (Section 1923(d) of the Social Security  
2406 Act) shall, subject to OBRA 1993 payment limitations, receive an  
2407 additional DSH payment. This additional DSH payment shall expend  
2408 the balance of the federal DSH allotment and associated state  
2409 share not utilized in DSH payments to state-owned institutions for  
2410 treatment of mental diseases. The payment to each hospital shall  
2411 be calculated by applying a uniform percentage to the uninsured  
2412 costs of each eligible hospital, excluding state-owned  
2413 institutions for treatment of mental diseases; however, that  
2414 percentage for a state-owned teaching hospital located in Hinds  
2415 County shall be multiplied by a factor of two (2).



2416           (h) Public hospitals permanently classified in (but not  
2417 reclassified to) the Gulfport-Biloxi, MS Core-Based Statistical  
2418 Area (CBSA) for hospital wage index purposes and eligible for  
2419 Deficit Reduction Act Hurricane Katrina Related Stabilization  
2420 Grants under Section 6201(a)(4) of the Deficit Reduction Act of  
2421 2005 shall qualify for DSH payments as follows: (i) critical  
2422 access hospitals that were forced to cease operations for more  
2423 than thirty (30) days as a direct result of Hurricane Katrina  
2424 shall receive a multiple of two (2) times the DSH amount, and (ii)  
2425 hospitals with more than four hundred (400) licensed beds and  
2426 greater than thirty-five percent (35%) of total patient days  
2427 during 2007 from Medicaid patients shall receive a multiple of one  
2428 and one-half (1-1/2) times the DSH amount. This paragraph shall  
2429 stand repealed on July 1, 2011.

2430           (For state fiscal year 2010, the state shall use uninsured  
2431 costs from the 2009 hospital survey. For state fiscal year 2011,  
2432 the state shall use costs from the 2010 hospital survey.)

2433           (11) The hospital assessment provided in subsection (4) of  
2434 this section shall not be in effect or implemented until the SPA  
2435 is approved by CMS.

2436           (12) The division shall implement DSH and UPL calculation  
2437 methodologies that result in the maximization of available federal  
2438 funds.

2439           (13) The DSH and inpatient UPL payments shall be paid on or  
2440 before December 31, March 31, and June 30 of each fiscal year, in  
2441 increments of one-third (1/3) of the total calculated DSH and  
2442 inpatient UPL amounts.

2443           (14) The hospital assessment as described in subsection (4)  
2444 above shall be assessed and collected quarterly a maximum of ten  
2445 (10) days before making the DSH and inpatient UPL payments;  
2446 provided, however, that the first quarterly payment shall be  
2447 assessed but not be collected until collection is made for the  
2448 second quarterly payment.



(15) Hospitals shall receive the Medicare published market basket inflationary index payment increase annually.

(16) If for any reason any part of the plan for additional annual DSH and inpatient UPL payments to hospitals provided under subsection (10) of this section is not approved by CMS, the remainder of the plan shall remain in full force and effect.

(17) Subsections (10) through (16) of this section shall stand repealed on July 1, 2012.

**[If the hospital assessment provided in the above amendment to subsection (4) does not take effect or cease to be imposed, the provisions of Section 43-13-145 shall remain in effect as existed on June 30, 2009, and this section shall read as follows:]**

43-13-145. (1) (a) Upon each nursing facility licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, not exceeding the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.

(b) A nursing facility is exempt from the assessment levied under this subsection if the facility is operated under the direction and control of:

(i) The United States Veterans Administration or other agency or department of the United States government;

(ii) The State Veterans Affairs Board;

(iii) The University of Mississippi Medical Center; or

(iv) A state agency or a state facility that either provides its own state match through intergovernmental transfer or certification of funds to the division.

(2) (a) Upon each intermediate care facility for the mentally retarded licensed by the State of Mississippi, there is levied an assessment in an amount set by the division, not exceeding the maximum rate allowed by federal law or regulation, for each licensed and occupied bed of the facility.



2482                   (b) An intermediate care facility for the mentally  
2483 retarded is exempt from the assessment levied under this  
2484 subsection if the facility is operated under the direction and  
2485 control of:

2486                   (i) The United States Veterans Administration or  
2487 other agency or department of the United States government;

2488                   (ii) The State Veterans Affairs Board; or

2489                   (iii) The University of Mississippi Medical  
2490 Center.

2491           (3) (a) Upon each psychiatric residential treatment  
2492 facility licensed by the State of Mississippi, there is levied an  
2493 assessment in an amount set by the division, not exceeding the  
2494 maximum rate allowed by federal law or regulation, for each  
2495 licensed and occupied bed of the facility.

2496                   (b) A psychiatric residential treatment facility is  
2497 exempt from the assessment levied under this subsection if the  
2498 facility is operated under the direction and control of:

2499                   (i) The United States Veterans Administration or  
2500 other agency or department of the United States government;

2501                   (ii) The University of Mississippi Medical Center;  
2502 or

2503                   (iii) A state agency or a state facility that  
2504 either provides its own state match through intergovernmental  
2505 transfer or certification of funds to the division.

2506           (4) (a) Upon each hospital licensed by the State of  
2507 Mississippi, there is levied an assessment in the amount of Three  
2508 Dollars and Twenty-five Cents (\$3.25) per bed for each licensed  
2509 inpatient acute care bed of the hospital.

2510                   (b) A hospital is exempt from the assessment levied  
2511 under this subsection if the hospital is operated under the  
2512 direction and control of:

2513                   (i) The United States Veterans Administration or  
2514 other agency or department of the United States government;



2515                   (ii) The University of Mississippi Medical Center;  
2516 or

2517                   (iii) A state agency or a state facility that  
2518 either provides its own state match through intergovernmental  
2519 transfer or certification of funds to the division.

2520           (5) Each health care facility that is subject to the  
2521 provisions of this section shall keep and preserve such suitable  
2522 books and records as may be necessary to determine the amount of  
2523 assessment for which it is liable under this section. The books  
2524 and records shall be kept and preserved for a period of not less  
2525 than five (5) years, and those books and records shall be open for  
2526 examination during business hours by the division, the State Tax  
2527 Commission, the Office of the Attorney General and the State  
2528 Department of Health.

2529           (6) The assessment levied under this section shall be  
2530 collected by the division each month beginning on March 31, 2005.

2531           (7) All assessments collected under this section shall be  
2532 deposited in the Medical Care Fund created by Section 43-13-143.

2533           (8) The assessment levied under this section shall be in  
2534 addition to any other assessments, taxes or fees levied by law,  
2535 and the assessment shall constitute a debt due the State of  
2536 Mississippi from the time the assessment is due until it is paid.

2537           (9) (a) If a health care facility that is liable for  
2538 payment of an assessment levied by the division does not pay the  
2539 assessment when it is due, the division shall give written notice  
2540 to the health care facility by certified or registered mail  
2541 demanding payment of the assessment within ten (10) days from the  
2542 date of delivery of the notice. If the health care facility  
2543 fails or refuses to pay the assessment after receiving the notice  
2544 and demand from the division, the division shall withhold from any  
2545 Medicaid reimbursement payments that are due to the health care  
2546 facility the amount of the unpaid assessment and a penalty of ten  
2547 percent (10%) of the amount of the assessment, plus the legal rate



2548 of interest until the assessment is paid in full. If the health  
2549 care facility does not participate in the Medicaid program, the  
2550 division shall turn over to the Office of the Attorney General the  
2551 collection of the unpaid assessment by civil action. In any such  
2552 civil action, the Office of the Attorney General shall collect the  
2553 amount of the unpaid assessment and a penalty of ten percent (10%)  
2554 of the amount of the assessment, plus the legal rate of interest  
2555 until the assessment is paid in full.

2556 (b) As an additional or alternative method for  
2557 collecting unpaid assessments levied by the division, if a health  
2558 care facility fails or refuses to pay the assessment after  
2559 receiving notice and demand from the division, the division may  
2560 file a notice of a tax lien with the circuit clerk of the county  
2561 in which the health care facility is located, for the amount of  
2562 the unpaid assessment and a penalty of ten percent (10%) of the  
2563 amount of the assessment, plus the legal rate of interest until  
2564 the assessment is paid in full. Immediately upon receipt of  
2565 notice of the tax lien for the assessment, the circuit clerk shall  
2566 enter the notice of the tax lien as a judgment upon the judgment  
2567 roll and show in the appropriate columns the name of the health  
2568 care facility as judgment debtor, the name of the division as  
2569 judgment creditor, the amount of the unpaid assessment, and the  
2570 date and time of enrollment. The judgment shall be valid as  
2571 against mortgagees, pledgees, entrusters, purchasers, judgment  
2572 creditors and other persons from the time of filing with the  
2573 clerk. The amount of the judgment shall be a debt due the State  
2574 of Mississippi and remain a lien upon the tangible property of the  
2575 health care facility until the judgment is satisfied. The  
2576 judgment shall be the equivalent of any enrolled judgment of a  
2577 court of record and shall serve as authority for the issuance of  
2578 writs of execution, writs of attachment or other remedial writs.



2579           **SECTION 4.** Section 43-13-407, Mississippi Code of 1972, as  
2580 amended by House Bill No. 1505, 2009 Regular Session, is amended  
2581 as follows:

2582           43-13-407. (1) In accordance with the purposes of this  
2583 article, there is established in the State Treasury the Health  
2584 Care Expendable Fund, into which shall be transferred from the  
2585 Health Care Trust Fund the following sums:

2586                   (a) In fiscal year 2005, Four Hundred Fifty-six Million  
2587 Dollars (\$456,000,000.00);

2588                   (b) In fiscal year 2006, One Hundred Eighty-six Million  
2589 Dollars (\$186,000,000.00);

2590                   (c) In fiscal year 2007, One Hundred Eighty-six Million  
2591 Dollars (\$186,000,000.00);

2592                   (d) In fiscal year 2008, One Hundred Six Million  
2593 Dollars (\$106,000,000.00);

2594                   (e) In fiscal year 2009, Ninety-two Million Two Hundred  
2595 Fifty Thousand Dollars (\$92,250,000.00);

2596                   (f) In the fiscal year beginning after the calendar  
2597 year in which none of the amount of the annual tobacco settlement  
2598 installment payment will be deposited into the Health Care  
2599 Expendable Fund as provided in subsection (3)(d) of this section,  
2600 and in each fiscal year thereafter, a sum equal to the average  
2601 annual amount of the dividends, interest and other income,  
2602 including increases in value of the principal, earned on the funds  
2603 in the Health Care Trust Fund during the preceding four (4) fiscal  
2604 years.

2605           (2) In any fiscal year in which interest, dividends and  
2606 other income from the investment of the funds in the Health Care  
2607 Trust Fund are not sufficient to fund the full amount of the  
2608 annual transfer into the Health Care Expendable Fund as required  
2609 in subsection (1)(f) of this section, the State Treasurer shall  
2610 transfer from tobacco settlement installment payments an amount





2611 that is sufficient to fully fund the amount of the annual  
2612 transfer.

2613 (3) Beginning with calendar year 2009, at the time that the  
2614 State of Mississippi receives the tobacco settlement installment  
2615 payment for each calendar year, the State Treasurer shall deposit  
2616 the following amounts of each of those installment payments into  
2617 the Health Care Expendable Fund:

2618 (a) In calendar years 2009 and 2010, the total amount  
2619 of the installment payment;

2620 (b) In calendar year 2011, the amount of the  
2621 installment payment less Ten Million Dollars (\$10,000,000.00);

2622 (c) In calendar year 2012, the amount of the  
2623 installment payment less Twenty Million Dollars (\$20,000,000.00);

2624 (d) In calendar year 2013, and each calendar year  
2625 thereafter, the amount of the installment payment to be deposited  
2626 into the Health Care Expendable Fund shall be reduced by an  
2627 additional Ten Million Dollars (\$10,000,000.00) each calendar year  
2628 until the calendar year that the amount of the installment payment  
2629 that otherwise would be deposited into the Health Care Expendable  
2630 Fund is less than the average annual amount of the dividends,  
2631 interest and other income, including increases in value of the  
2632 principal, earned on the funds in the Health Care Trust Fund  
2633 during the preceding four (4) fiscal years. Beginning with that  
2634 calendar year and each calendar year thereafter, none of the  
2635 amount of the installment payment shall be deposited into the  
2636 Health Care Expendable Fund.

2637 (4) The total sum of Two Hundred Forty Million Dollars  
2638 (\$240,000,000.00) plus interest at the rate of five percent (5%)  
2639 per annum shall be transferred into the Health Care Trust Fund  
2640 from the State General Fund during fiscal years 2011 through 2018  
2641 to repay the trust fund for Two Hundred Forty Million Dollars  
2642 (\$240,000,000.00) of the total sum that is transferred from the  
2643 trust fund to the Health Care Expendable Fund during fiscal year



2644 2005 under subsection (1)(a) of this section. The repayment shall  
2645 be made according to the following schedule: During each of  
2646 fiscal years 2011 through 2017, the State Fiscal Officer shall  
2647 transfer from the General Fund to the Health Care Trust Fund the  
2648 sum of Thirty-eight Million Dollars (\$38,000,000.00), and during  
2649 fiscal year 2018 the State Fiscal Officer shall transfer from the  
2650 State General Fund to the Health Care Trust Fund a sum in the  
2651 amount certified by the State Treasurer as necessary to fully  
2652 repay the balance of the Two Hundred Forty Million Dollars  
2653 (\$240,000,000.00) plus interest at the rate of five percent (5%)  
2654 per annum.

2655       (5) If Medicaid expenditures are projected to exceed the  
2656 amount of funds appropriated to the Division of Medicaid in any  
2657 fiscal year in excess of the expenditure reductions to providers,  
2658 funds shall be transferred by the State Fiscal Officer from the  
2659 Health Care Trust Fund into the Health Care Expendable Fund and  
2660 then to the Governor's Office, Division of Medicaid, in the amount  
2661 and at such time as requested by the Governor to reconcile the  
2662 deficit.

2663       (6) All income from the investment of the funds in the  
2664 Health Care Expendable Fund shall be credited to the account of  
2665 the Health Care Expendable Fund. Any funds in the Health Care  
2666 Expendable Fund at the end of a fiscal year shall not lapse into  
2667 the State General Fund.

2668       (7) The funds in the Health Care Expendable Fund shall be  
2669 available for expenditure under specific appropriation by the  
2670 Legislature beginning in fiscal year 2000, and shall be expended  
2671 exclusively for health care purposes.

2672       (8) The provisions of subsection (1) of this section may not  
2673 be changed in any manner except upon amendment to that subsection  
2674 by a bill enacted by the Legislature with a vote of not less than  
2675 three-fifths (3/5) of the members of each house present and  
2676 voting.



2677       (9) Subsections (1), (2), (5), (6) and (7) of this section  
2678 shall stand repealed on July 1, 2012.

2679       **SECTION 5.** This act shall take effect and be in force from  
2680 and after July 1, 2009.



Admin. Code Part 200, Rule 2.2 including removing duplicative language, effective 12/01/2015; Added Miss. Admin. Code Part 200, Rule 2.2 A. 36. and Rule 2.2 D. eff. 10/01/2014; Rule 2.2 B. and 2.2 C. added to correspond with approved SPA 2011-004 and 2011-006 effective 10/01/11 and SPA 2012-001 effective 06/01/2012.

*Rule 2.3: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles*

- A. A state is not required to cover any Medicare cost sharing expenses related to payment for deductibles, coinsurance, or co-payments for dual eligibles which exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dual eligible. When a state's payment for Medicare cost-sharing for a dual eligible is reduced or eliminated the Medicare payment plus the state's Medicaid payment is considered payment in full. The dually eligible beneficiary cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment.
- B. Medicare Part A crossover nursing facility, hospice and home health agency claims for dually eligible beneficiaries are reimbursed as listed below:
  - 1. The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a beneficiary who is not dually eligible.
  - 2. All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.
  - 3. All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.
- C. For Medicare Part A crossover claims from hospitals (inpatient) and all Part B crossover claims, Medicaid reimburses the full deductible and coinsurance amount for dual eligibles.

Source: Miss. Code Ann. § 43-13-121; Balanced Budget Act of 1997

**Part 200 Chapter 3: Beneficiary Information**

*Rule 3.1: Coverage of Eligibility Groups*

- A. The Division of Medicaid covers full Medicaid benefits for the following eligibility groups:
  - 1. Individuals receiving Supplemental Security Income (SSI),
  - 2. Certain former SSI recipients specified in federal and/or state law,